

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12134
12122										CERTIFICATE OF DEATH
1. DECEASED-NAME (Type or print) <b>Mildred Adams</b>					2a. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>11:15A</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 8, 1882</b>		6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>1</b>		IF UNDER 24 HRS. HOURS <b>11</b> MIN <b>15</b>
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			Md.	
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fahrney- Keedy Mem. Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Clearspring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First <b>James</b> Middle <b>Coleman</b> Last <b>Adams</b>				15. MOTHER'S MAIDEN NAME First <b>Henreitta</b> Middle <b>Eddy</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>220-46-7629</b>		17. INFORMANT <b>Boonsboro, Md. Fahrney- Keedy Home Records, Rfd. 1</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension &amp; cardio Vascular Disease</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>443X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1968</b> , to <b>Aug 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>G. W. LeVan</b>					DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 10, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>					22e. ADDRESS <b>Boonsboro Ind.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Clearspring, Wash. Co., Md.</b>				
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>					25a. REC'D BY REGISTRAR <b>AUG 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Bast, Jr.</b>			



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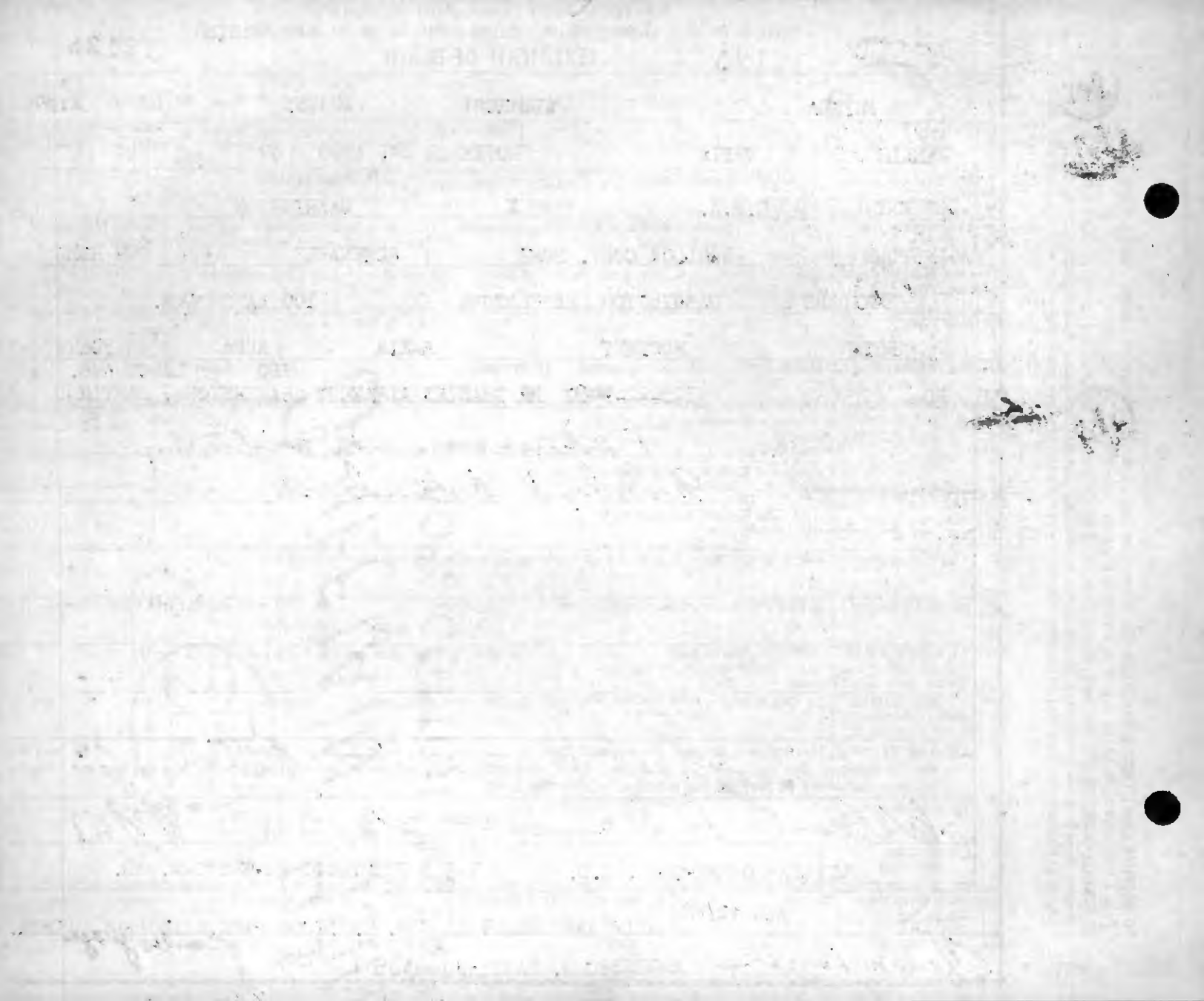
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

12125

12135

1. DECEASED-NAME (Type or print) <b>FRIEDA</b>			First Middle Lost			2a. DATE OF DEATH <b>AUGUST</b> Month <b>8</b> Day <b>68</b> Year			2b. HOUR <b>2:30 a.m.</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>NOVEMBER 24, 1898</b>			6. AGE (In years last birthday) <b>69</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>GERMANY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b> Md.		
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GARLOCK CONV. HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOME MAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HAGERSTOWN</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>100 LARCH AVE.</b>			14. FATHER'S NAME <b>PETER</b>			15. MOTHER'S MAIDEN NAME <b>MARIA</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. <b>193-22-9460</b>			17. INFORMANT <b>MR CHARLES ALBRECHT</b>			18. ADDRESS <b>100 LARCH AVE. HAGERSTOWN, MARYLAND</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parkinsonism with Decubitus Ulcers.</b> 342 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 350 X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>present</b> , 19 <b>68</b> , that (we) last saw the deceased alive on <b>July 13th 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William O Rexrode</b>			22c. DATE SIGNED <b>8/8/68</b>			22d. PHYSICIAN'S NAME (Type) <b>WILLIAM O REXRODE, M.D.</b>			22e. ADDRESS <b>145 S PROSPECT, HAGERSTOWN, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>AUG 12/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ALLEGHANY MEMORIAL CEM.</b>			23d. LOCATION (City or Town) (County) (State) <b>ALLISON PARK ALLEGHANY PENNA.</b>		
24. FUNERAL DIRECTOR <b>Charles M. Ronger</b>			25a. REC'D BY REGISTRAR <b>AUG 12 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



12126

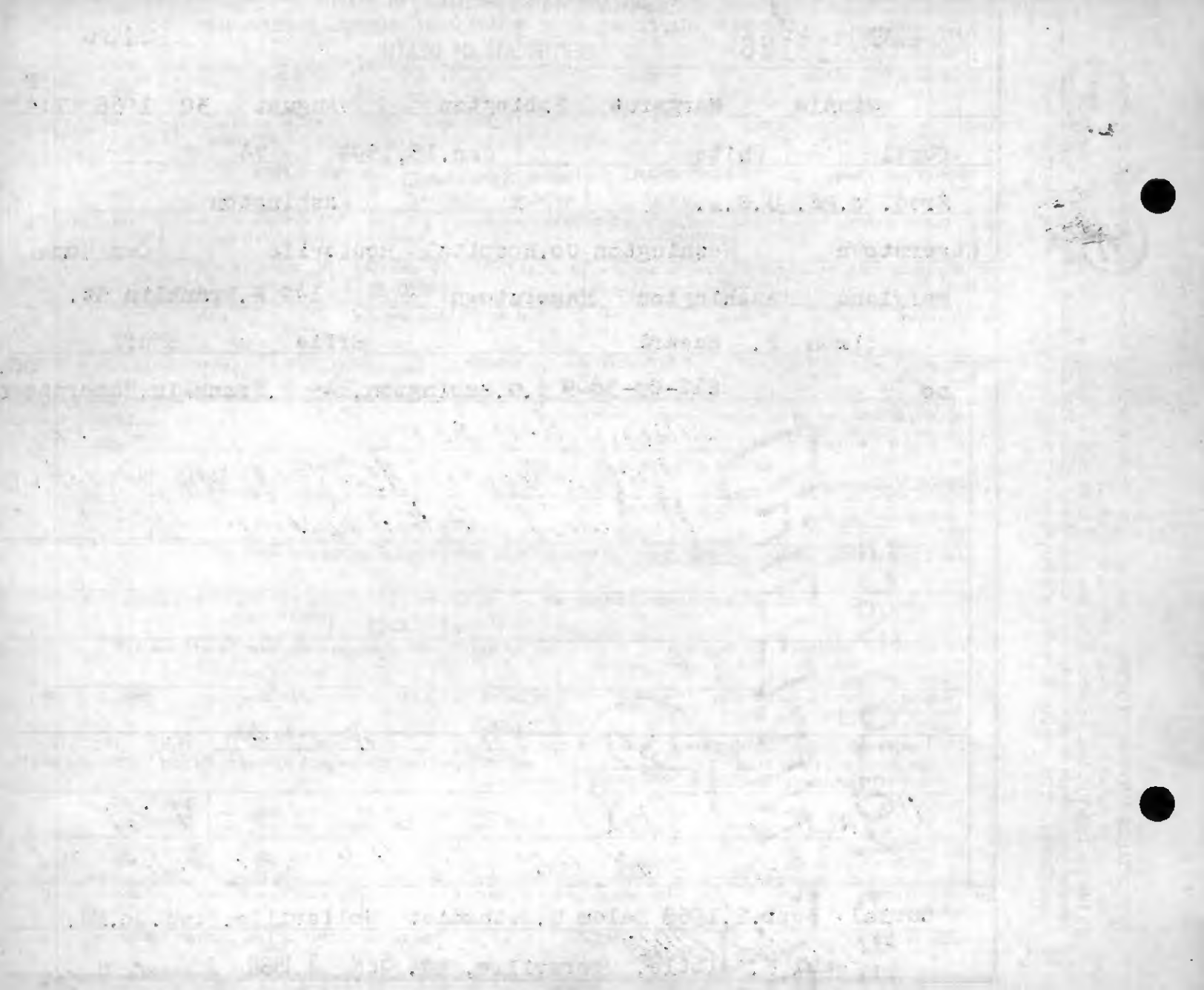
## CERTIFICATE OF DEATH

12136

1. DECEASED-NAME (Type or print) Minnie Margaret Babington			2a. DATE OF DEATH Month Day Year August 30 1968			2b. HOUR 7:47 PM					
3. SEX female		4. RACE white		5. DATE OF BIRTH Jan. 18, 1894		6. AGE (In years lost birthday) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Fred. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 149 W. Franklin St.			
14. FATHER'S NAME First Middle Last Simon P. Eccard			15. MOTHER'S MAIDEN NAME First Middle Last Effie Shuff			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. 212-03-3809		
17. INFORMANT Address C.G. Babington, 149 W. Franklin, Hagerstown Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CHRONIC HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GASTROENTERIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) REMITTENT ASTHMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8:30, 1968, to 8:30, 1968, that (I) (we) last saw the deceased alive on 8:30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E.R. Lutzgarn M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/2/68					
22d. PHYSICIAN'S NAME (Type) E.R. Lutzgarn M.D.		22e. ADDRESS 300 N. Belmont Hagerstown Md.									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Sept. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Salem U. Methodist		23d. LOCATION (City or Town) (County) (State) Wolfsville, Fred. Co. Md.					
24. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md.		25a. REC'D BY REGISTRAR SEP 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

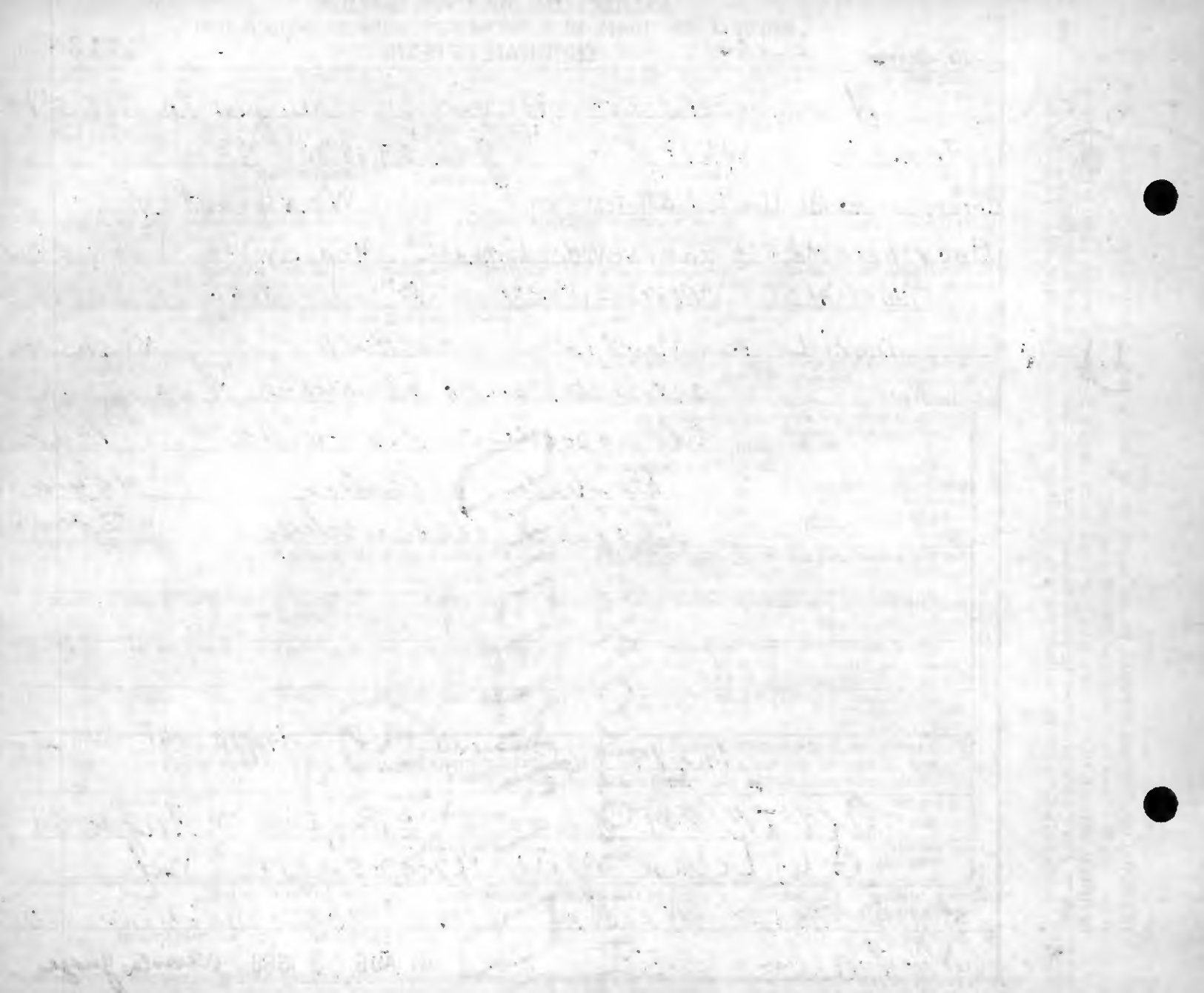
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12127									
12137									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		7b. HOUR	
Paul			Franklin			August 8 1968		10:25 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7c. IF UNDER 1 YEAR	
Male		White		February 27, 1920		48		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Hagerstown, Md.			USA					Washington	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington County Hospital			Fork Lift Operator		Truck Mfg.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Washington			Hagerstown		224 Norway Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Robert A Bailey			Sarah Fink						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			219-05-2125			Mrs. Norma Bailey 224 Norway Ave. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Carcinoma Of Lung</u>									
DUE TO, OR AS A CONSEQUENCE OF									
1621									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Acute Cardiac Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
163x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1968, to Aug. 8, 1968, that (I) (we) last saw the deceased alive on Aug. 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
A. E. W. Dittie, Jr.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		Aug. 9, 1968	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Dr. E. W. Dittie, Jr.						215 W. Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8/11/68		Rest Haven Cemetery		Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. Hoxford						DATE AUG 13 1968		Charles Judge	
Rest Haven Funeral Chapel						Hagerstown, Md.			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Nina BEYINGTON Bear</b>						2a. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>5:20 P M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 29, 1893</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>10</b>		IF UNDER 24 HRS. HOURS <b>5</b> MIN <b>20</b>	
7a. BIRTHPLACE (State or foreign country) <b>Covers Corner, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.					
10. CITY OR TOWN OF DEATH <b>Boonsboro, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fabryney Keedymen Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>RIDGEVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>NONE</b>			
14. FATHER'S NAME First <b>David W</b> Middle <b>Martin</b> Last <b>Martin</b>				15. MOTHER'S MAIDEN NAME First <b>RACHAEL</b> Middle <b>Nusbaum</b> Last <b>Nusbaum</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>218-12-6069</b>		17. INFORMANT Address <b>THELMA SHUEMAKER YELLOW SPRINGS MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic cardio vascular</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Haemorrhage</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>10 yrs</b> <b>3 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1968</b> , to <b>Aug 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 19, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. W. LeVan M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>Aug 20, 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>G. W. LeVan M.D.</b>						22e. ADDRESS <b>Boonsboro, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>AUG 23 - 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOCUST GROVE</b>		23d. LOCATION (City or Town) (County) (State) <b>LIBERTYTOWN RURAL MD</b>					
24. FUNERAL DIRECTOR <b>DR Hartzler &amp; Sons Libertytown, Md</b>						25a. REC'D BY REGISTRAR <b>DATE AUG 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

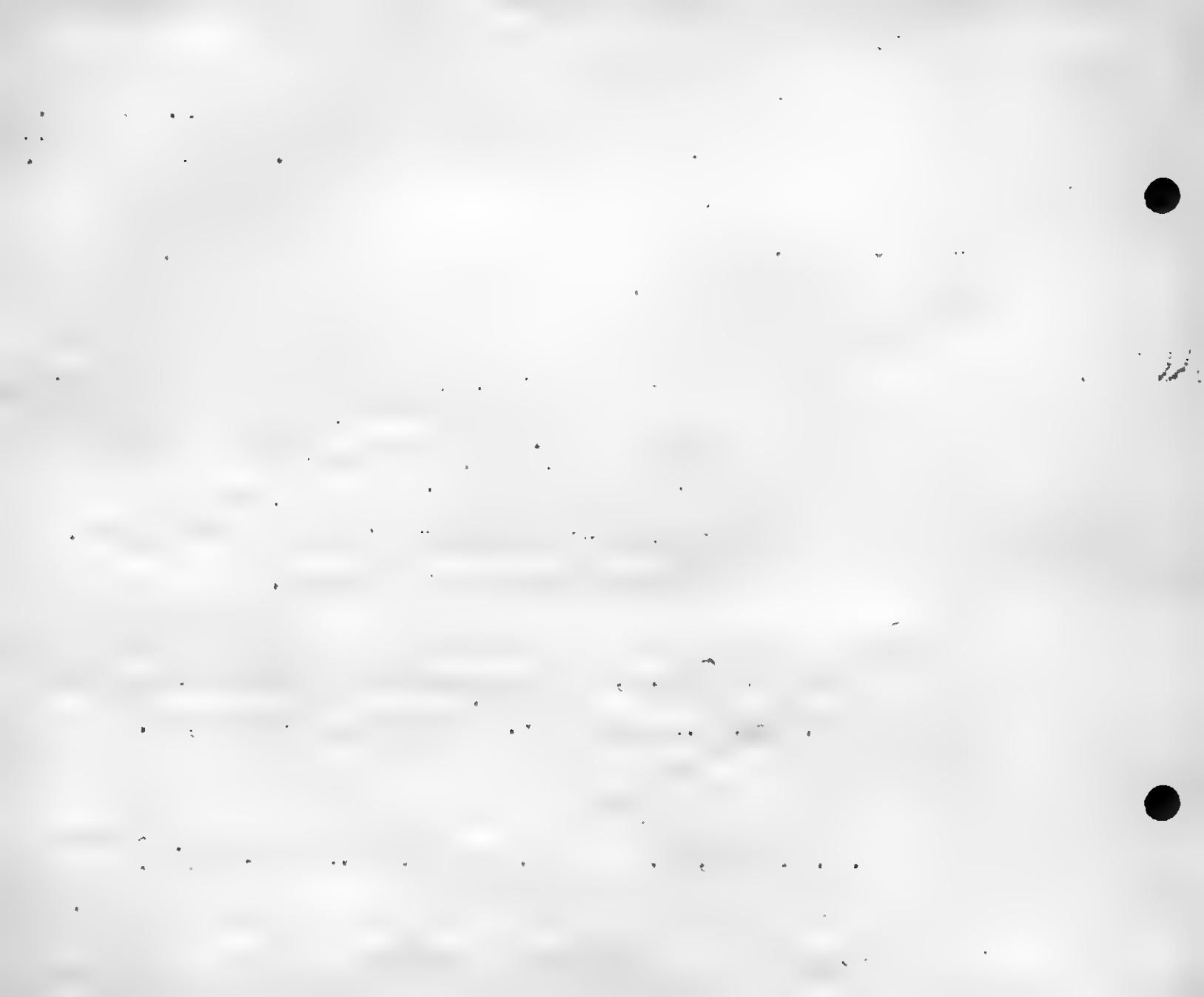


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-31-68 Item 228 mt #43										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12729										12129 139									
1. DECEASED NAME (Type or Print)										2a. DATE KNOWN OF DEATH									
First CHARLES Middle GEORGE Last BITTORF										Month Day 68 19									
3 SEX M 4 RACE WHITE 5 DATE OF BIRTH MAR 1, 1890 6 AGE 78 YRS										2c. DATE PRONOUNCED DEAD									
										Month Day Year 168									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U. S. A.									
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH WASHINGTON COUNTY									
10 CITY OR TOWN OF DEATH HAGERSTOWN, MD.										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL									
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TELEGRAPH OPER										12b. KIND OF BUSINESS OR INDUSTRY RAILROAD									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND COUNTY WASH. CO. HAGERSTOWN										13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET AND NUMBER 807 WASHINGTON AVE.																			
14. FATHER'S NAME First GEORGE Middle Last BITTORF										15. MOTHER'S MAIDEN NAME First CHRISTINA Middle Last ROSSBACH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) NO										16b. SOCIAL SECURITY NO. 705-10-8771									
17 INFORMANT MRS. BEATRICE BITTORF										ADDRESS 807 WASH. AVE. HAGERSTOWN, MD									
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage in Rt. Basal Ganglia & Cerebral										5 hours									
DUE TO, OR AS A CONSEQUENCE OF Hemisphere, With Destruction Of																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																			
(b) Parietal & Temporal Lobes.																			
DUE TO, OR AS A CONSEQUENCE OF Extension Of Hemorrhage Into Ventricular																			
(c) System, Pia-Arachnoid Layer, & (probably) Subdural Space.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
Old Hemorrhage Into Right Basal Ganglia.																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>										21b. TIME OF INJURY Month, Day Year 4:30 PM Aug. 21, 19 68									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Head on collision with rear of car in front of him.																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) W. Wash. St., & Elgin Blvd. Hagerstown, Washington, Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Dr. E. W. Ditte, Jr.										22b. DATE SIGNED Aug. 23, 1968									
EXAMINER'S NAME (Type) Dr. E. W. Ditte, Jr.										215 W. Washington St., Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE AUGUST 24, 1968									
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.										23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH CO., MD									
24. FUNERAL DIRECTOR W. T. Harriott										25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
ADDRESS Hagerstown Md										DATE AUG 26 1968									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1-58

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last <b>Charles Nicholas Bohn</b>			2a. DATE OF DEATH Month Day Year <b>August 9, 1968</b>			2b. TIME <b>10:30 PM</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>March 19, 1880</b>			6 AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign) <b>Carroll Co. Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md					
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>Fahrney-Keedy Mem. Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HARDWARE</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Carroll Union Bridge</b>			13c. CITY OR TOWN <b>Union Bridge</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>MAIN ST.</b>			
14 FATHER'S NAME First Middle Last <b>Reuben Bohn</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Effie Irene Garber</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216-03-6417</b>			17. INFORMANT <b>Fahrney-Keedy Home Records, Boonsboro, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>Instantly</u>													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4211</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. _____ 19__		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 9, 1968</u> , to <u>Aug 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>G. W. Van M.D.</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Aug 10, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>G. W. Van M.D.</u>						22e. ADDRESS <u>Boonsboro, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>8/13/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		23d. LOCATION (City or Town) (County) (State) <u>NEW WINDSOR CARROLL MD</u>							
24. FUNERAL DIRECTOR <u>D. D. Hartzler &amp; Sons Union Bridge</u>						25a. REC'D BY REGISTRAR DATE <u>AUG 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



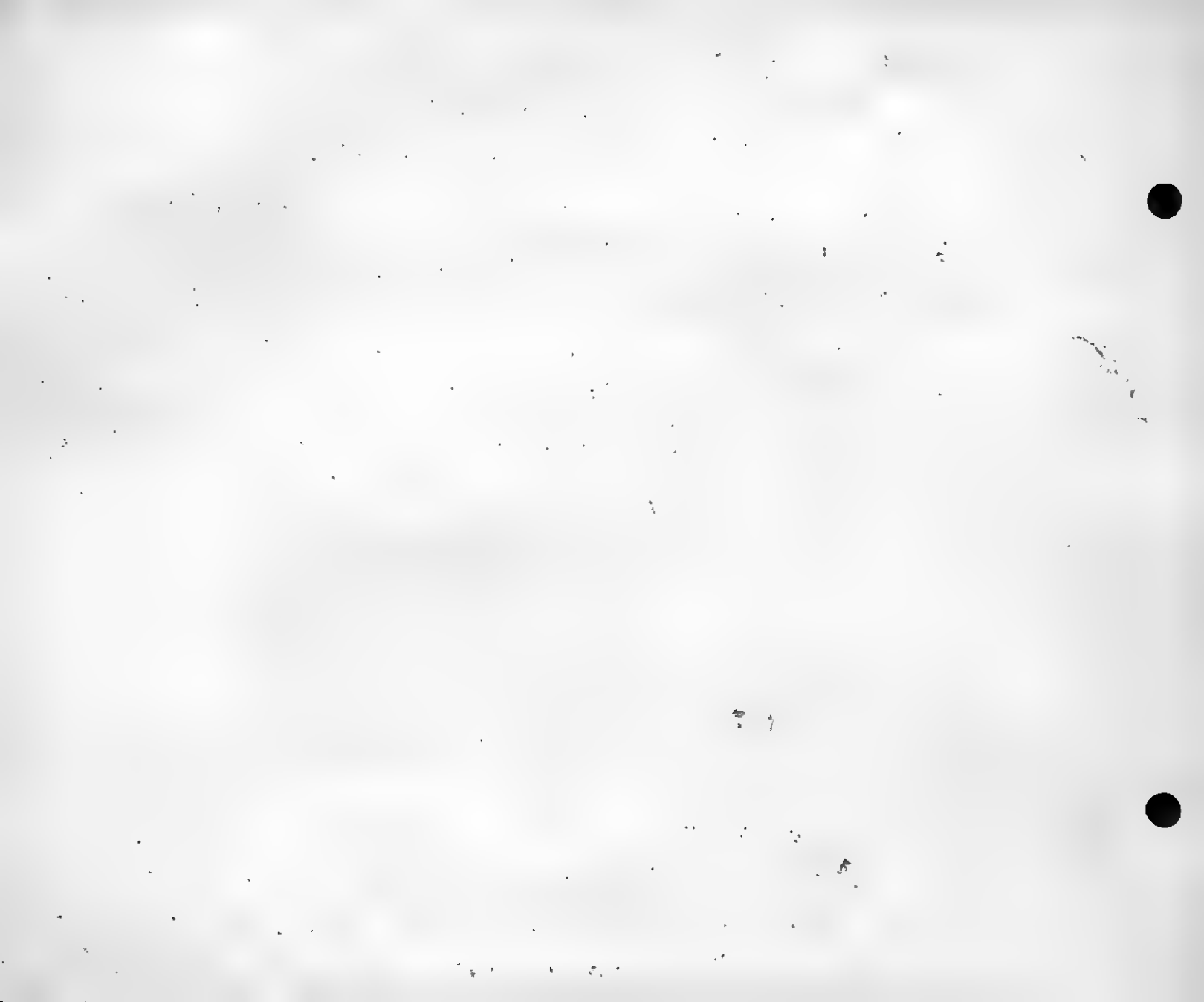
1-131

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <b>Sarah Ann Brewet</b>			2a. DATE OF DEATH Month Day Year <b>8 6 68</b>			2b. HOUR <b>9:10 P.M.</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>3-22-1883</b>		6. AGE (In years lost birthday) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Williamsport</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Homewood Church Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md</b>		13b. CITY OR TOWN <b>Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>912 Hamilton Blvd</b>			
14. FATHER'S NAME First Middle Last <b>John J. Hamilton</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Ann Ralston</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO <b>217-42-7696</b>		17. INFORMANT <b>Mark Wagner</b>		Address <b>2750 Va Ave Wmsport</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive @ V Dis</b> DUE TO, OR AS A CONSEQUENCE OF (c) BETWEEN ONSET AND DEATH: <b>Today's</b> <b>10 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 20, 1968</b> to <b>8-6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-6</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert P. Conrad</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8-6-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>				22e. ADDRESS <b>137 W. Washington Hagerstown, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Aug 8-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>			
24. FUNERAL DIRECTOR <b>ANDREW K. COFFMAN FUNERAL HOME, INC.</b>				ADDRESS <b>Hagerstown Md</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

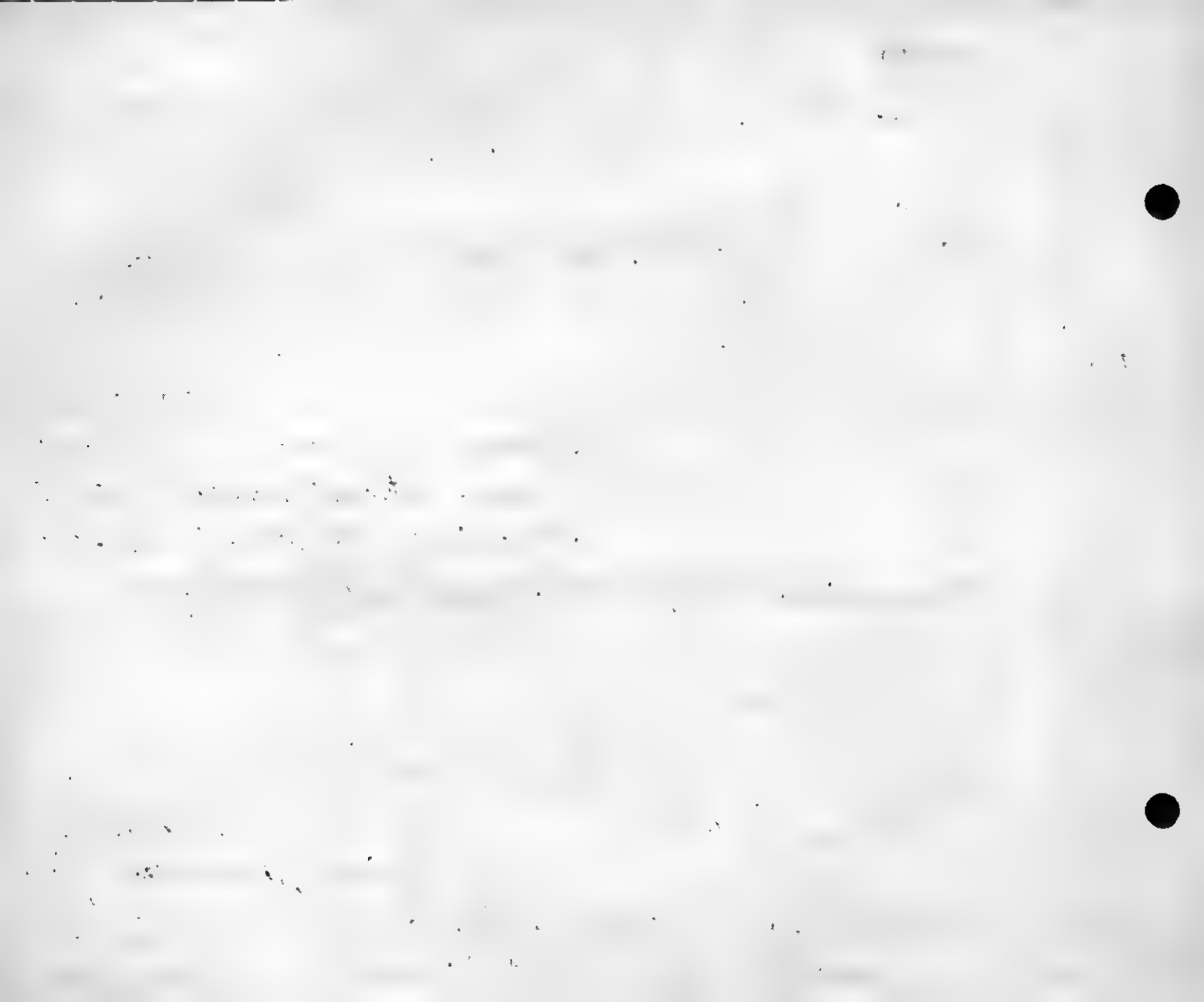
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10132 1968 142 CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First Sarah		Middle F		Last Buckley		2a DATE OF DEATH Month 14 Day 1968		2b HOUR 11:50 P.M.	
3 SEX female		4 RACE white		5 DATE OF BIRTH Jan 22, 1888		6 AGE (In years last birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.					
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cashier		12b KIND OF BUSINESS OR INDUSTRY restaurant			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md				13b. COUNTY Pro George's		13c CITY OR TOWN Greenbelt		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9 G Laurel Hill Road	
14. FATHER'S NAME First Middle Last Barney J French				15. MOTHER'S MAIDEN NAME First Middle Last Fannie E. Moreland							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b SOCIAL SECURITY NO 578 093 811		17 INFORMANT Barbara E Buckley				Address Greenbelt, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized arteriosclerosis years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1m med	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) healed duodenal ulcer, pulmonary emphysema, nephrosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4-21, 1968, to 8-14, 1968, that (I) (we) last saw the deceased alive on 8-13-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edwin G Riley				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-15-68			
22d. PHYSICIAN'S NAME (Type) Edwin G Riley				22e. ADDRESS 1500 Penna, Hagerstown, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Middletown Association		23d. LOCATION (City or town) Middletown		(County) Dauphin		(State) Pa.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10133

CERTIFICATE OF DEATH

12143

1 DECEASED NAME (Type or print) <i>Tillie Josephine Burgess</i>			2a. DATE OF DEATH Month <i>Aug</i> Day <i>7</i> Year <i>1968</i>			2b. HOUR <i>11:55P</i>			
3 SEX <i>FEMALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH <i>MAY 10 1896</i>		6. AGE (In years last birthday) <i>72</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>KANSAS</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>WASHINGTON</i>			
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WESTERN MD. STATE HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>PRINCE GEORGES</i>		13c. CITY OR TOWN <i>LANHAM</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5520 BELVA, ST.</i>	
14 FATHER'S NAME First Middle Last <i>KIRKEMINDE</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>UNKNOWN</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17 INFORMANT <i>PAUL F. BURGUS</i>		Address <i>SAME AS #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobular pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral vascular infarct</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3d</i> <i>2 yrs</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Two old MI's, renal calculus, chronic pyelonephritis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>6-19</i> , 19 <i>67</i> , to <i>8-7</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>8-7</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Edwin G. Riley M.D.</i>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>8-8-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>EDWIN G. RILEY, M.D.</i>		22e. ADDRESS <i>1500 Puma, Hagerstown Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>8-9-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>SUTLAND MARYLAND</i>			
24 FUNERAL DIRECTOR <i>W.W. CHAMBERS CO. RIVERDALE, MD</i>				25a. REC'D BY REGISTRAR DATE <i>AUG 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

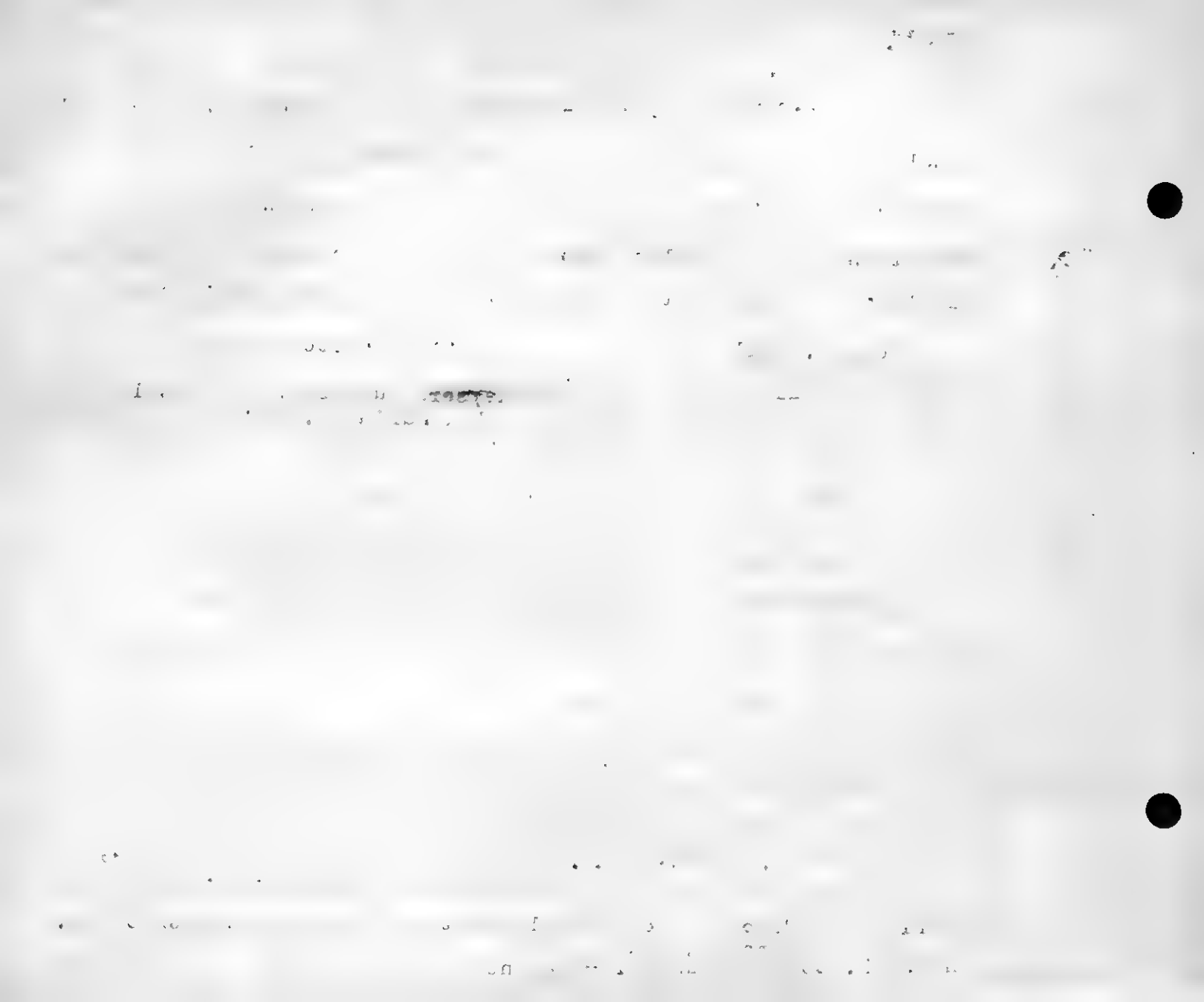


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>MARY MAGDELENE STRITE-BUSSARD</b>						2a. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>3 P M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 3 1888</b>			6. AGE (In years lost birthday) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington</b> Md.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Avalon Manor</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>402 Summit Ave</b>		
14. FATHER'S NAME First <b>John H.</b> Middle <b>Heil</b> Last <b>Heil</b>				15. MOTHER'S MAIDEN NAME First <b>Clara Rebecca</b> Middle <b>Gross</b> Last <b>Gross</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <b>---</b>		17. INFORMANT Address <b>Walter H. Bussard 2908 Russell Rd Alexandria Va. 22305</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>15 years?</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>10-9, 1938</b> , to <b>8-28, 1968</b> , that (I) (we) lost the deceased alive on <b>8-17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>John H. Hornbaker M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8-28-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>				22e. ADDRESS <b>154 West Washington St., Hagerstown, Md. 21740</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md.</b>						
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md</b>		25a. RECEIVED BY REGISTRAR <b>AUG 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>				

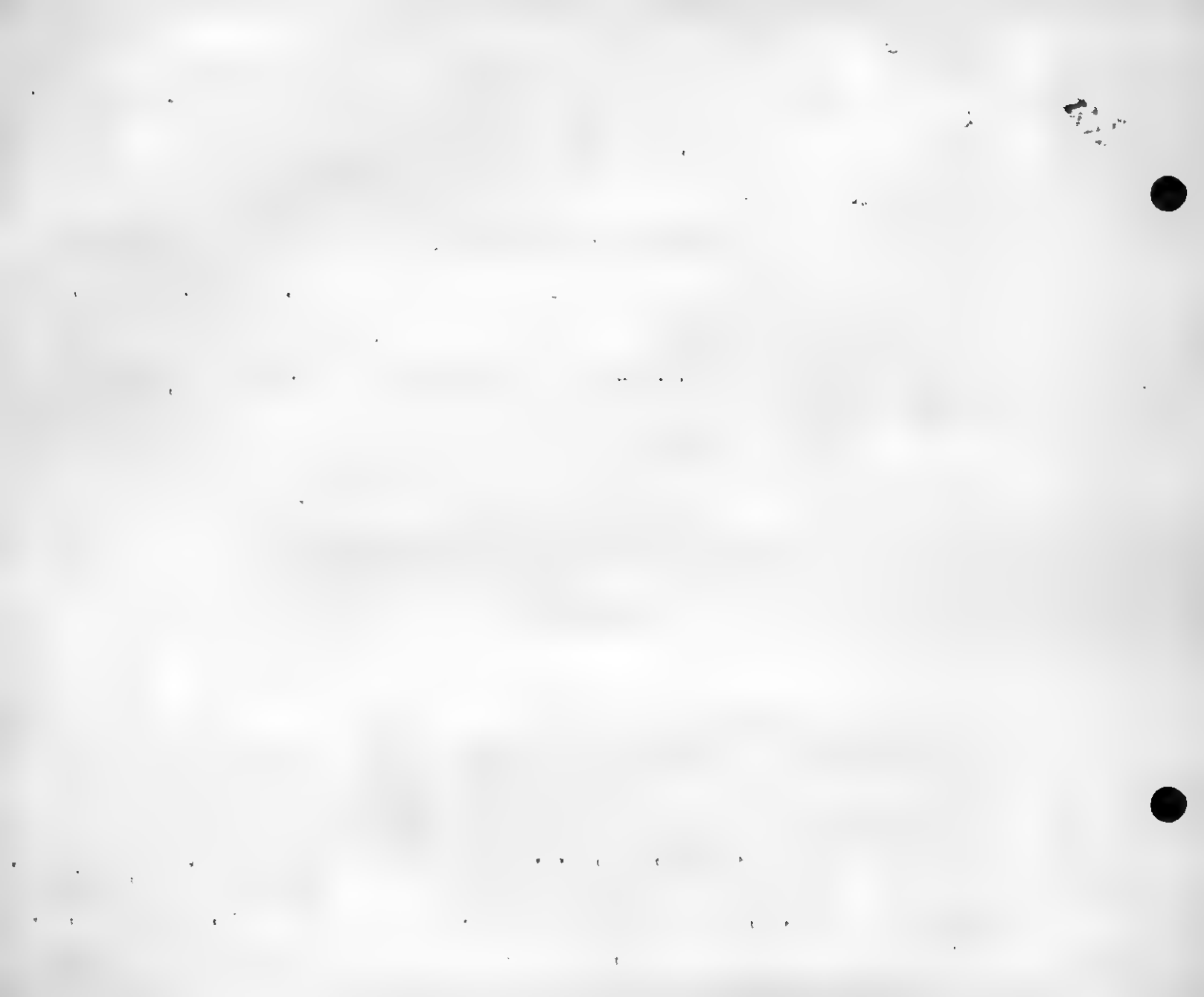


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Earl Leroy Byers						Month Day Year		9:15 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	March 30, 1910	58 YRS	4 MONTHS 15 DAYS		Month Day Year		10:15 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland		USA				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington County Hospital			Laborer		Tannery	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Washington Williamsport			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8 S. Conococheague St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
John Harvey Byers			Bessie Viola Sterling						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
No			214-10-3982			Miss Janice Byers Williamsport, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombotic Occlusion of</u>									14-6 hr
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Cerebral Artery</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Cerebral Arteriosclerosis, Severe</u>									15 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			8-6-68			
Edward W. Ditto, III, M.D.			DEPUTY MEDICAL EXAMINER			217 W. Washington St.			
			ADDRESS (Street, city, town, or county)			Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Aug. 18, 1968		Greenlawn Cemetery		Williamsport, Washington, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Albert L. Leaf Williamsport, Maryland.					DATE AUG 20 1968		Charles Judge		



## CERTIFICATE OF DEATH

1146

1 DECEASED NAME (Type or print)			2a DATE OF DEATH			2b HOUR					
Catherine CONNER BYRON			AUGUST 13 68			6:20 PM					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR			
FEMALE		WHITE		NOVEMBER 18, 1893		74 YRS		IF UNDER 24 MRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10 UNDER 24 MRS			
MARYLAND		U.S.A.				WASHINGTON		MONTHS DAYS HOURS M N			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			AVALON MANOR NURSING HOME			SECRETARY			AMERICAN CANCER		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND			WASHINGTON			HAGERSTOWN			13e STREET AND NUMBER		
									1334 POTOMAC AVE.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		
ASHBY			ADDIE			NO			220-18-1606		
17 INFORMANT			18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the breast with multiple metastases			19 ADDRESS			20 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
EDWARD J BYRON			DUE TO, OR AS A CONSEQUENCE OF			1334 POTOMAC AVE.			Indefinite		
			DUE TO, OR AS A CONSEQUENCE OF			HAGERSTOWN, MARYLAND					
			DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			19 P.M.								
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No			City or Town		
									County		
									State		
22a. I certify that (I) (we) attended the deceased from Sept. 18, 1964, to Aug. 13, 1968, that (I) (we) last saw the deceased alive on Aug. 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
B.B. KNEISLEY									8/14/68		
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS			22f. REGISTRAR'S SIGNATURE					
B.B. KNEISLEY, M.D.			145 W. WASHINGTON ST., HAGERSTOWN, MD.			f Charles Judge					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			8/16/68			XXX ROSE HILL CEMETERY			HAGERSTOWN WASHINGTON MD.		
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
			HAGERSTOWN, MARYLAND			DATE AUG 19 1968					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10137- CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Hazel Bernice Cairns						8 Month 24 Day 68 Year			10:45 P M		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
Female			White			4-9-1892			76 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Canton, Ohio			U. S. A.						Washington Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Boonsboro			Fahney-Redykone			ARMY OFFICE			LAW		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD			CARROLL NEW WINDSOR			YES			CHURCH ST.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
CHARLES SELL			ANNA PERRAUX								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
NO			NONE			ROBERT CAIRNS			NEW WINDSOR MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordal Hemorrhage										3 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular										10 years	
DUE TO, OR AS A CONSEQUENCE OF (c) Thrombotic embolism										10 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 10, 1968, to Aug 27, 1968, that (I) (we) last saw the deceased alive on Aug 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
G. W. HeVan M.D.			Aug 27, 1968			G. W. HeVan M.D.			Boonsboro Md		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			AUG 27-1968			PIPE CREEK			NEW WINDSOR RURAL MD		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
D. D. Hartzler & Sons			New Windsor			DATE AUG 28 1968			Charles Judge		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A.M. P.M.		
Lily			Cromwell			August 18, 1968		6:00 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
female		white		2-11-1882		86 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
West Virginia		USA				Washington Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of workable, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Wash. County Hospital		Sewer		Chemical Mfg.				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Wash.		Hagerstown				1100 Virginia, Ave.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
James W. Chenoweth				Emma McCalele						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no			214-09-4893		Mrs. Virginia S. Clopper Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, chronic, RLL.</u> 517X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerosis, arteriosclerotic Heart Disease.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> , 19 <u>68</u> , to <u>8/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>George Jennings</u> M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8/19/68</u>				
22d. PHYSICIAN'S NAME (Type) <u>George Jennings</u>				22e. ADDRESS <u>318 N. Potomac St. Hagerstown, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		8-20-68		Rose Hill Cemetery		Hagerstown, Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Minnich Funeral Home Hagerstown, Md.				AUG 23 1968		<u>Charles Judge</u>				



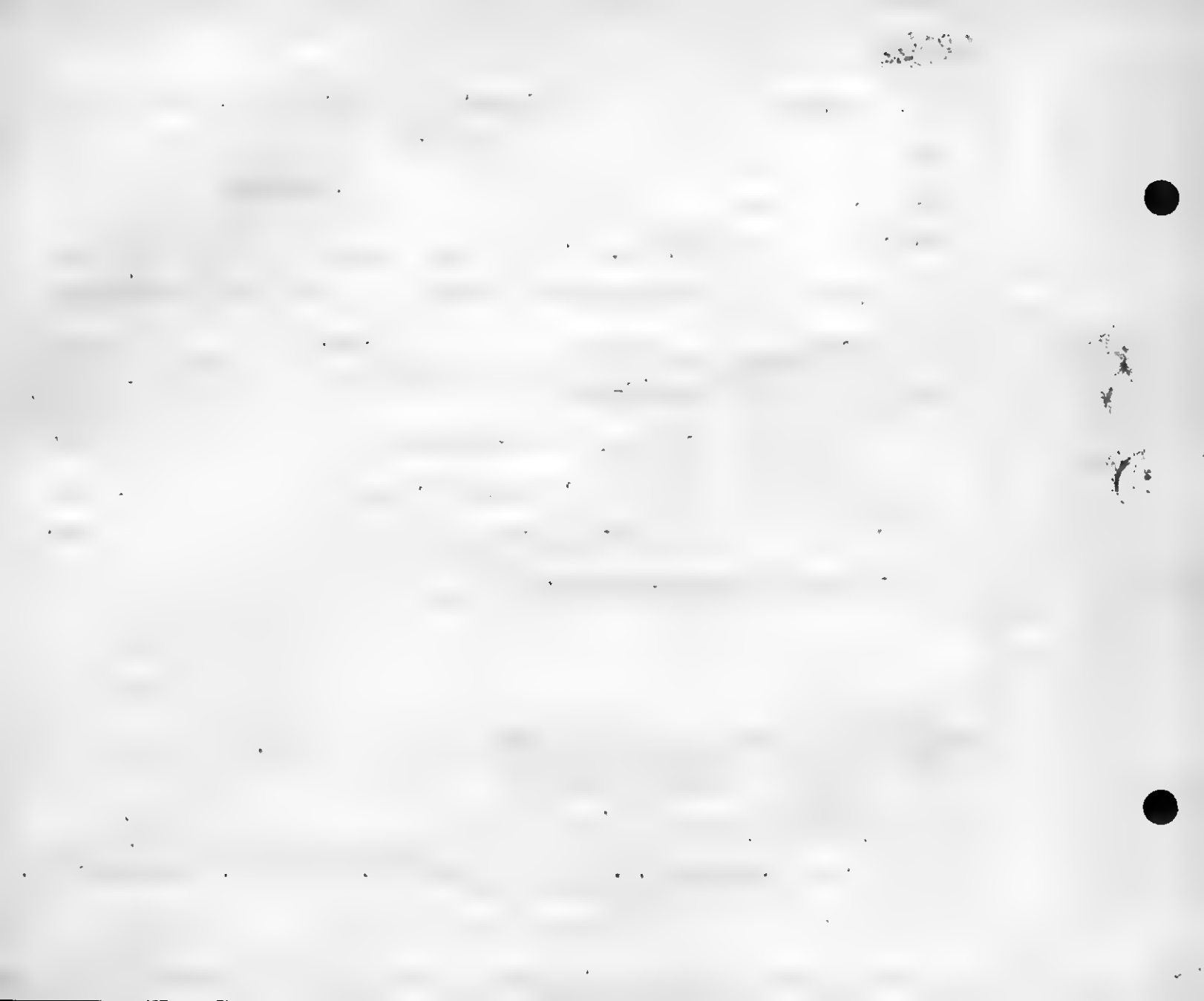
10139

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Benjamin</b>			First Middle Last <b>Chopenik</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>4:37</b> A M		
3 SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>7/14/07</b>			6 AGE (In years last birthday) <b>61</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Connecticut</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b> Md		
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Salesman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>Apt. T2</b>			13f. STREET AND NUMBER <b>1927 East West Highway</b>								
14. FATHER'S NAME First Middle Last <b>Nathan Chopenik</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Fox</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>264-40-2125</b>			17. INFORMANT <b>Eva Chopenik</b>			Address <b>1909 Rosemary Hills Dr., #2-8-5 Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>Bilateral amputation above knees</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 22</b> , 19 <b>67</b> , to <b>Aug. 16</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>August 16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Chong Choon Han</b>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>8/16/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Chong Choon Han, M.D.</b>			22e. ADDRESS <b>Western Maryland State Hospital</b>			22f. ADDRESS <b>1500 Pennsylvania Ave., Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Aug. 18, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden</b>			23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Virginia</b>		
24. FUNERAL DIRECTOR <b>Donald M. Stein</b>			ADDRESS <b>232 Carroll</b>			25a. REC'D BY REGISTRAR <b>AUG 20 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
HEBREW MEMORIAL FUNERAL HOME St. N.W. Wash. D.C.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

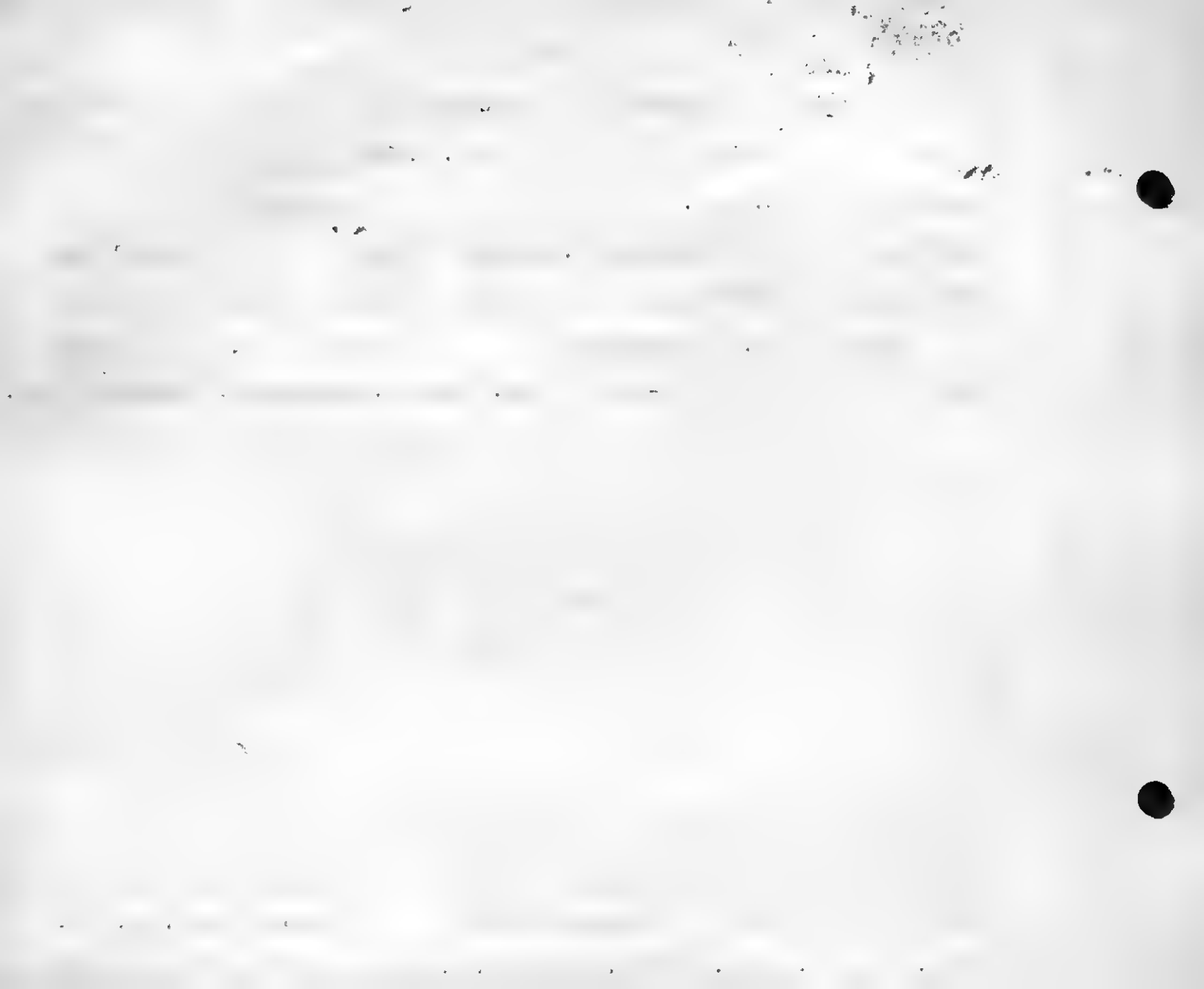
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Daniel Harold Chrissinger						August 31, 1968		9:45A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		Oct. 8, 1905		62 YRS.		10 23	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Boonsboro, Md.		U. S. A.				Washington Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington Co. Hospital		Labor		General Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Keedysville				Rfd. 1	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Elmer N. Chrissinger			Flora V. Moser						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
No.			224-10-8717		Mrs. Goldie M. Chrissinger, Keedysville, Rfd. 1, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC COR. ART. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) MASSIVE LEFT PLEURAL EFFUSION WITH ATELECTASIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/14, 1968, to 8/31, 1968, that (I) (we) last saw the deceased alive on 8/31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Amarillo					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/2/68		
22d. PHYSICIAN'S NAME (Type) R. Amarillo					22e. ADDRESS Sharpsburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9-3-68		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.					25a. REC'D BY REGISTRAR SEP 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10141									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			2a DATE OF DEATH			2b HOUR			
First Middle Last <b>Harry Martin Clark</b>			Month Day Year <b>August 18, 1968</b>			5:35 A.M.			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. IF UNDER 1 YEAR	
male		white		11-8-1891		76 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Washington Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of preceding life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Wash. County Hospital		Self Employed		Blacksmith			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		Wash.		Hagerstown				1144 Kuhn, Ave.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
John Clark			Flora Rowe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
no			212-10-1819		Mrs. Lillian Clark Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Andrew M. Mandell M.D.</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8-19-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Andrew M. Mandell. M. D.</u>				22e ADDRESS <u>301 E. Antietam Street Hagerstown, Md. 21740</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		8-21-68		Leitersburg Cemetery		Leitersburg, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md.				DATE <u>AUG 23 1968</u>		<u>Charles Judge</u>			

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30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
10142 CERTIFICATE OF DEATH 151												
1. DECEASED NAME (Type or print)			First John Middle Wesley Last Cline			2a. DATE OF DEATH Month August Day 26 Year 1968			2b. HOUR 1 P			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 31 1886			6. AGE (In years last b. rthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1140 Jefferson Blvd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1140 Jefferson Blvd.			
14. FATHER'S NAME First Middle Last Charles C. Cline			15. MOTHER'S MAIDEN NAME First Middle Last Sally Shupp									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. ==		17. INFORMANT Address Harold L. Cline Smithsburg Md R # 1							
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver toxemia - Ca Liver from Ca Pancreate DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 8 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 17:2												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1968, to 23 Aug, 1968, that (I) (we) last saw the deceased alive on 26 Aug 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE J. D. Wilson M.D.				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 8/27/68				
22d. PHYSICIAN'S NAME (Type) J. D. WILSON				22e. ADDRESS 580 NORTHERN AVE. - HAGERSTOWN, MD.								
23a. BURIAL, CREMATION, or other disposition		23b. DATE Aug. 29/68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) Hagerstown, Washington Md.		(County) (State)			
24. FUNERAL DIRECTOR Andrew K. Coffman				ADDRESS Hagerstown, Maryland.		25a. REC'D BY REGISTRAR DATE AUG 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

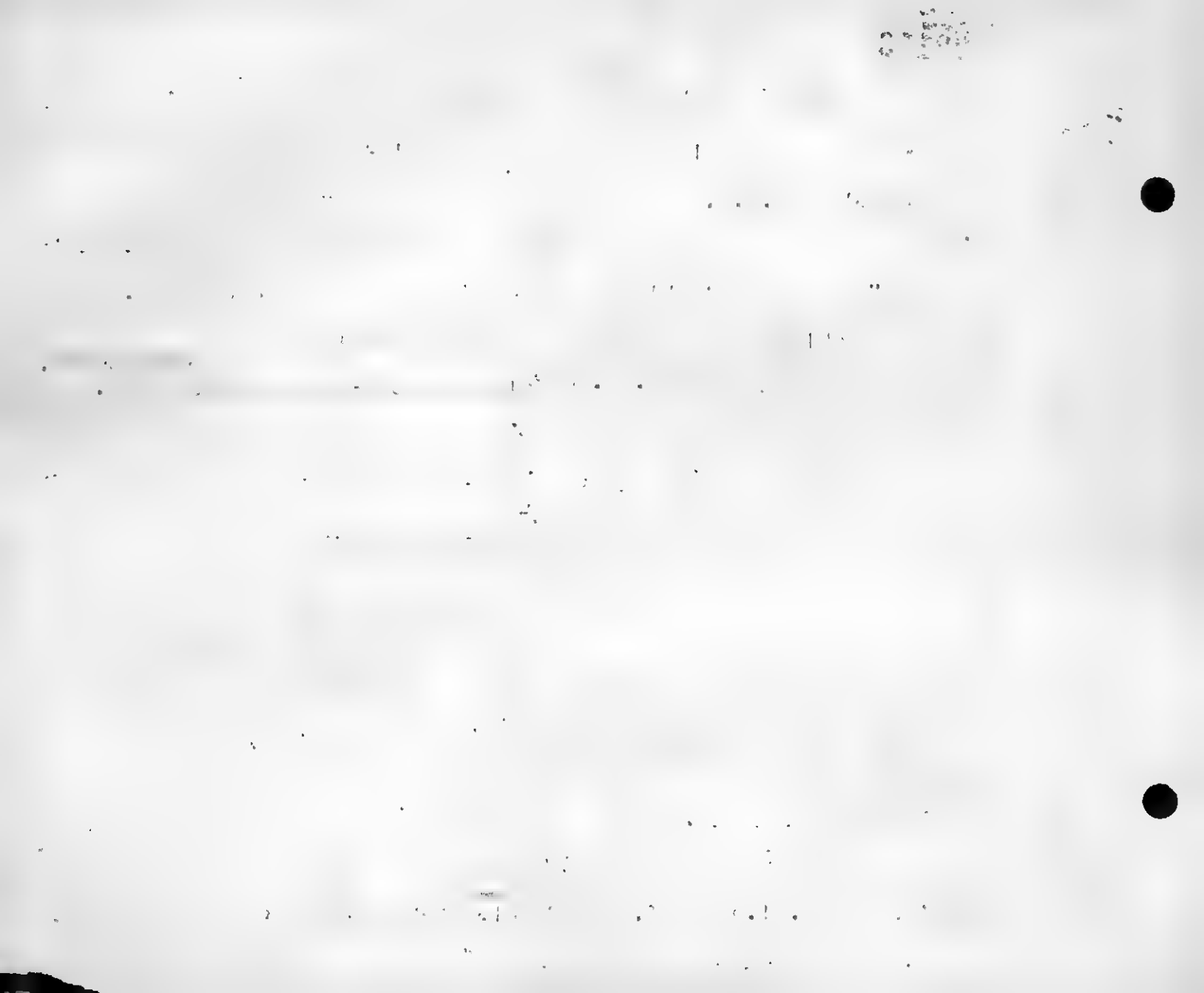
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12143

CERTIFICATE OF DEATH

12152

1. DECEASED-NAME (Type or print) <b>GEORGE WILLIAM COFFMAN</b>			2a. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>68</b>			2b. HOUR <b>4:10 P.M.</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JULY 24 1892</b>		6. AGE (In years last birthday) <b>76</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b>					
10. CITY OR TOWN OF DEATH <b>HANCOCK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>CARPENTER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HANCOCK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>139 FULTON ST.</b>	
14. FATHER'S NAME First Middle Last <b>WILLIAM COFFMAN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ALICE STARLIPER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give year or dates of service) <b>NO</b>					
16b. SOCIAL SECURITY NO <b>220.03.968</b>			17. INFORMANT Address <b>HANCOCK MD.</b> <b>MAILLIE M COFFMAN 139 FULTON ST.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Passive heart failure + A.S.H.D</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gen. arteriosclerosis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>20 months</b> <b>4 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>42</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/10/60</b> , 19____, to <b>8/19/68</b> , 19____, that (I) (we) lost the deceased alive on <b>8/16/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>FB Thomas III MD.</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>8/20/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>FB Thomas III MD.</b>			22e. ADDRESS <b>HANCOCK WASH MD.</b>								
23a. BURIAL, CREMATION, etc. <b>BURIAL</b>			23b. DATE <b>8.21.68</b>			23c. NAME OF CEMETERY OR CREMATOR <b>ST. THOMAS EPISCOPAL</b>			23d. LOCATION (City or Town) (County) (State) <b>HANCOCK WASHINGTON MD.</b>		
24. FUNERAL DIRECTOR <b>Howard F. Stone</b>			ADDRESS <b>Hancock Md</b>			25a. REC'D BY REGISTRAR DATE <b>AUG 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>forwards judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15 (4)  
REV

MIDDLE									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10144									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Allen Luther Crowl						Month Day Year		1:25A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		White		Oct. 15, 1897		70 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
Sharpsburg, Md.		U. S. A.		WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington Co., Hospital			Parts Clerk		Aircraft	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Washington			Boonsboro		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			417 N. Main St.			
Charles Crowl			Annie Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
Yes			214-16-0512			Mrs. Agnes C. Crowl, 417 N. Main St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Cancer						
1991			DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Metastasis to bladder						
			DUE TO, OR AS A CONSEQUENCE OF						
			6 mon						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
1991									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 10, 1968, to Aug 8, 1968, that (we) lost saw the deceased alive on Aug 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
G. W. Heelan M.D.			Aug. 9, 1968						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
G. W. Heelan			Boonsboro, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Buried			8-10-68			Boonsboro Cemetery		Boonsboro, Wash. Co., Md.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						AUG 12 1968		Charles Judge	

MEDICAL CERTIFICATION



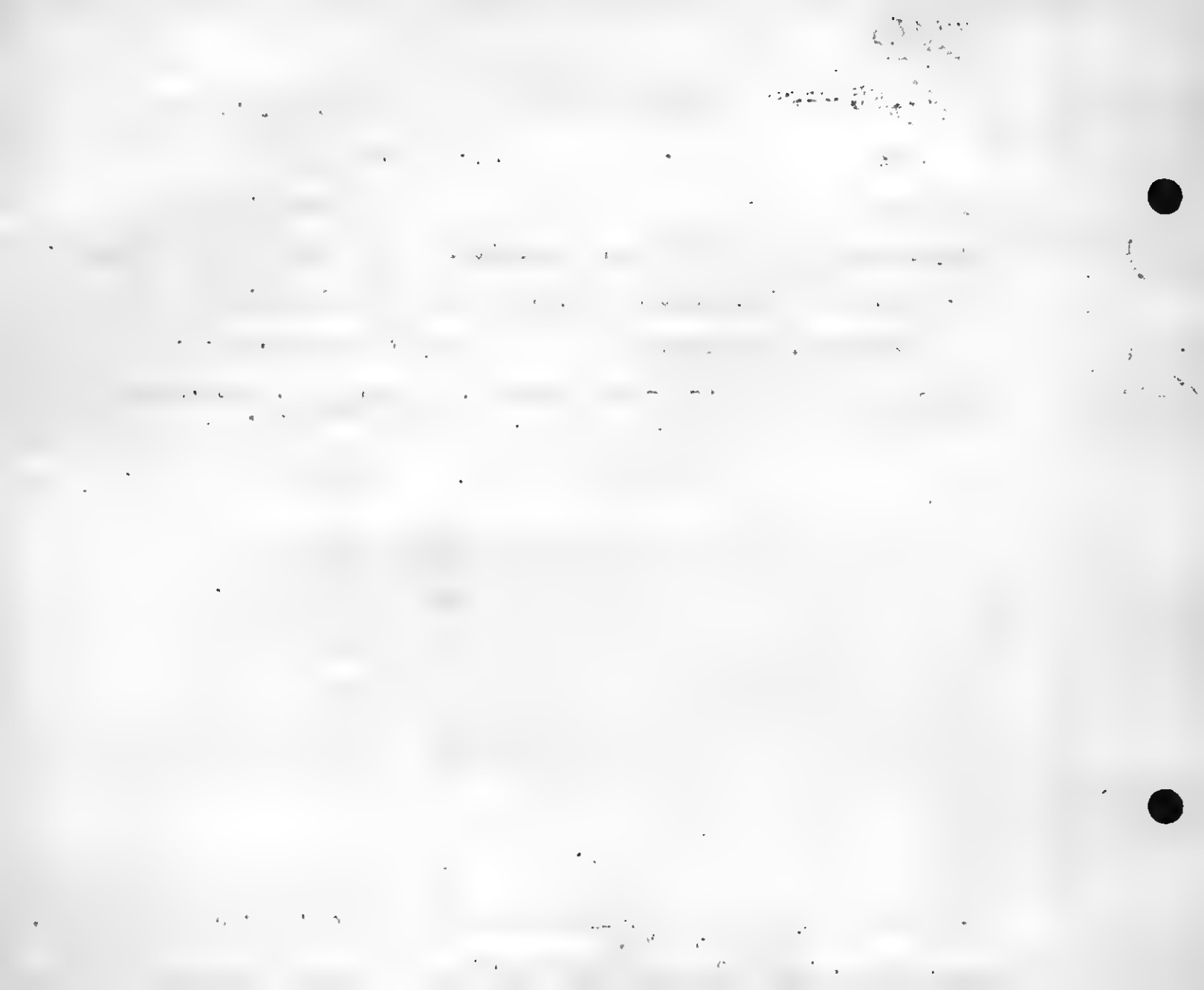
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Harry Edwin Eshelman</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1968</b>			2b. HOUR <b>7 PM</b>								
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Jan'y 22 1897</b>		6 AGE (In years last birthday) <b>71</b> YRS.		7 UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8 UNDER 24 HRS HOURS <b></b> MIN <b></b>				
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.								
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash County Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <b>Box Maker</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Box Factor</b>					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Washington</b>			13c CITY OR TOWN <b>Maugansville</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>116 Main St</b>		
14 FATHER'S NAME First Middle Last <b>Samuel W. Eshelman</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary A. Alberta Cearfoss</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-09-7101</b>			17 INFORMANT Address <b>Chas R. Madden 60 E. Washington St</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <b>7123</b> IMMEDIATE CAUSE (a) <b>congestive heart failure</b> 5 days DUE TO, OR AS A CONSEQUENCE OF, (b) <b>arteriosclerotic heart disease</b> Not known Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>August 14</b> , 19 <b>67</b> , to <b>August 17</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>August 17</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Timothy E. Eshelman</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <b>ARTURO RIEGO</b>						22e. ADDRESS <b>119 E. Antietam St. Hagerstown</b>								
23a. BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>			23b. DATE <b>8/20/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Broadfording Wash Co Md.</b>					
24. FUNERAL DIRECTOR <b>Hagerstown Md.</b> <b>Andrew K. Coffman Funeral Home Inc</b>						25a. REC'D BY REGISTRAR <b>AUG 21 1968</b>			25b. REGISTRAR'S SIGNATURE <b>James J. J...</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
1-140 CERTIFICATE OF DEATH 12156										
1 DECEASED-NAME (Type or print) First Middle Last <b>Edna Roessner Fiery</b>					2a. DATE OF DEATH Aug Month 31 Day 68 Year			2b. HOUR M		
3 SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>1-18-1900</b>		6. AGE (In years of birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wash.</b> Md.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>			12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>school</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>231 Taylor Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Edgar C. Fiery</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>L. Katie Roessner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16b. SOCIAL SECURITY NO <b>216-22-8949</b>		17. INFORMANT Address <b>John J. Fiery Hagerstown, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Purulent Pericarditis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>3822X</b> (b) <b>Hepatic + sub Phrenic abscess</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wks +</b> <b>2 mo +</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pulmonary Emboli - Multiple</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 19, 1968</b> , to <b>Aug. 31, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug. 31, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Lloyd A. Hoffman</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>9/3/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>					22e. ADDRESS <b>214 N. Potomac St, Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>9-3-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR <b>Minnich Funeral Home Hagerstown, Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1-10

1-10



2



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR A	
ANNA			MARIE	FLOWERS	AUGUST		14	1968	4:30 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS
FEMALE		WHITE		JANUARY 28 1906		62		YRS.		MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MARYLAND		U.S.A.				WASHINGTON				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN		WASHINGTON COUNTY HOSPITAL				HOUSEWIFE		HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND		WASHINGTON		HANCOCK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD #1		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
DAVID			POWELL		JULIA			SPIKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address				
NO				220-26-0558		LONEY E. FLOWERS RFD #1 HANCOCK, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Encarcerated, Large Ventral Hernia 10 yrs.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>5</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Aug 13/68		Small Bowel Obstruction			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County
										State
22a. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> , 19 <u>68</u> , to <u>8/14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		Francisco G. Japzon, MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>8/16/68</u>			
22d. PHYSICIAN'S NAME (Type)		FRANCISCO G. JAPZON			22e. ADDRESS		412 N. POTOMAC ST. HAGERSTOWN, MD. 21740			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
BURIAL		8/17/68		ST. PAUL'S LUTHERAN		RURAL HANCOCK WASH. MD.				
24 FUNERAL DIRECTOR		Howard J. Moore Hancock Md			25a. REC'D BY REGISTRAR DATE		AUG 20 1968		25b. REGISTRAR'S SIGNATURE Francis Judge	

100

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and the limitations of the experiment.

3. The third part of the report is a discussion of the results. It compares the results with the theoretical predictions and with the results of other experiments. It also discusses the implications of the results and the conclusions drawn from the study.

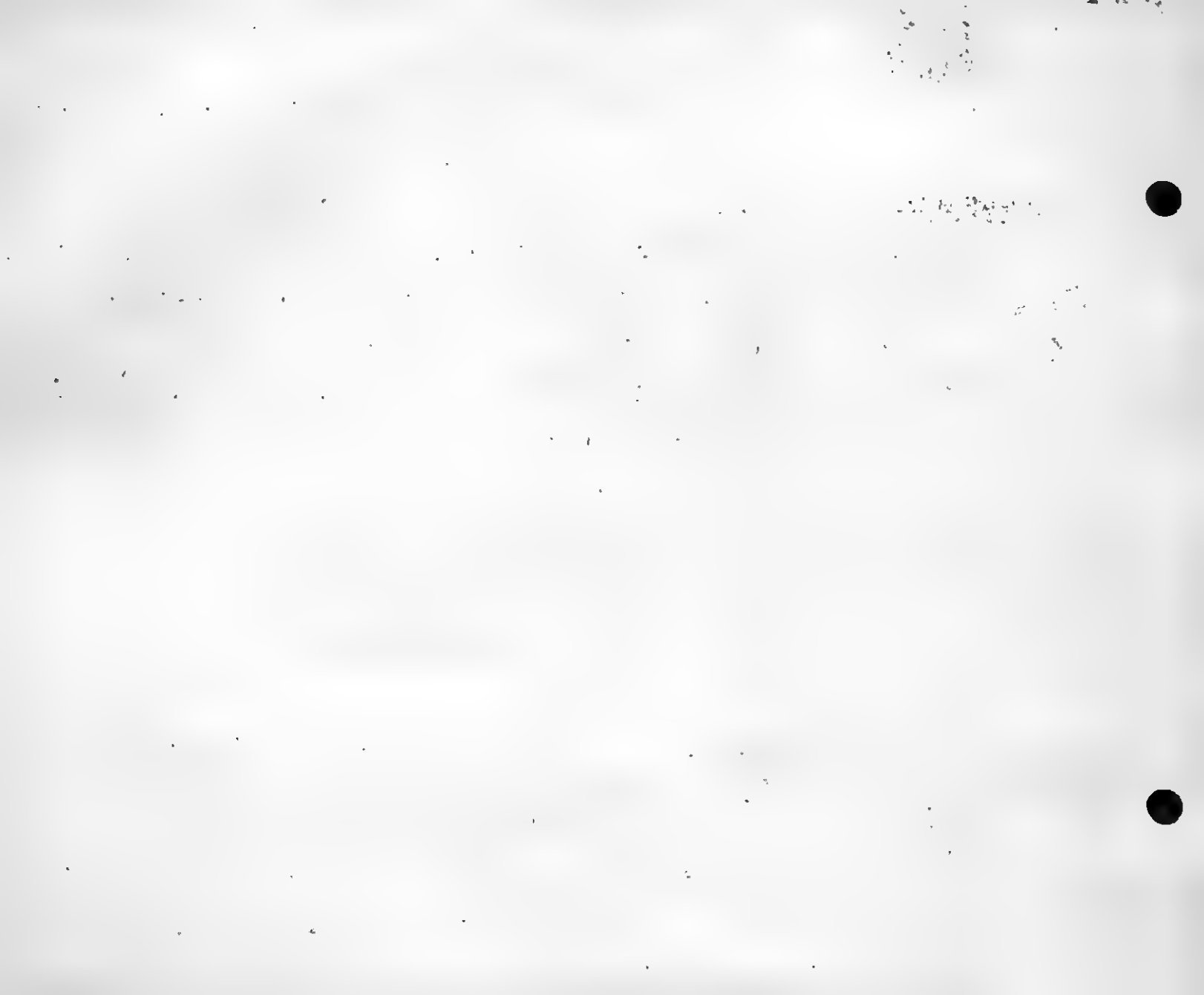
4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and states the conclusions drawn from the results. It also mentions the suggestions for further work.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent's certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>MAUDE BLANCHE FOUKE</b>			2a. DATE OF DEATH Month Day Year <b>AUGUST 21 68</b>			2b. HOUR <b>5:00a M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOVEMBER 9, 1888</b>		6. AGE (In years last birthday) YRS <b>79</b>	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.	
10. CITY OR TOWN OF DEATH <b>RURAL SANMAR</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>FAHRNEY-KEEDY NURSING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. JS. AL. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>1770 JEFFERSON BLVD.</b>		14. FATHER'S NAME First Middle Last <b>JOHN ANDREW MILLER</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>REBECCA SNELL CRIST</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO <b>173-03-1944</b>		17. INFORMANT Address <b>SHERWOOD DR. MRS. THELMA HENNEBERGER HAGERSTOWN, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>4127</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>6 yrs.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4206</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>19</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M.</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>(did not)</del> attended the deceased from <b>11/21</b> , 19 <b>64</b> , to <b>8/21</b> , 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>3/25</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> view the body after death.							
22b. SIGNATURE <b>Donald E. Martin</b>				22c. DATE SIGNED <b>8/21/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DONALD E. MARTIN, M.D.</b>				22e. ADDRESS <b>363 S. CLEVELAND, HAGERSTOWN, MARYLAND</b>			
23a. BURIAL, REMOVAL, (Specify)		23b. DATE <b>8/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASHINGTON MD.</b>	
24. FUNERAL DIRECTOR <b>Charles H. Reiger</b>				25a. REC'D BY REGISTRAR <b>HAGERSTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



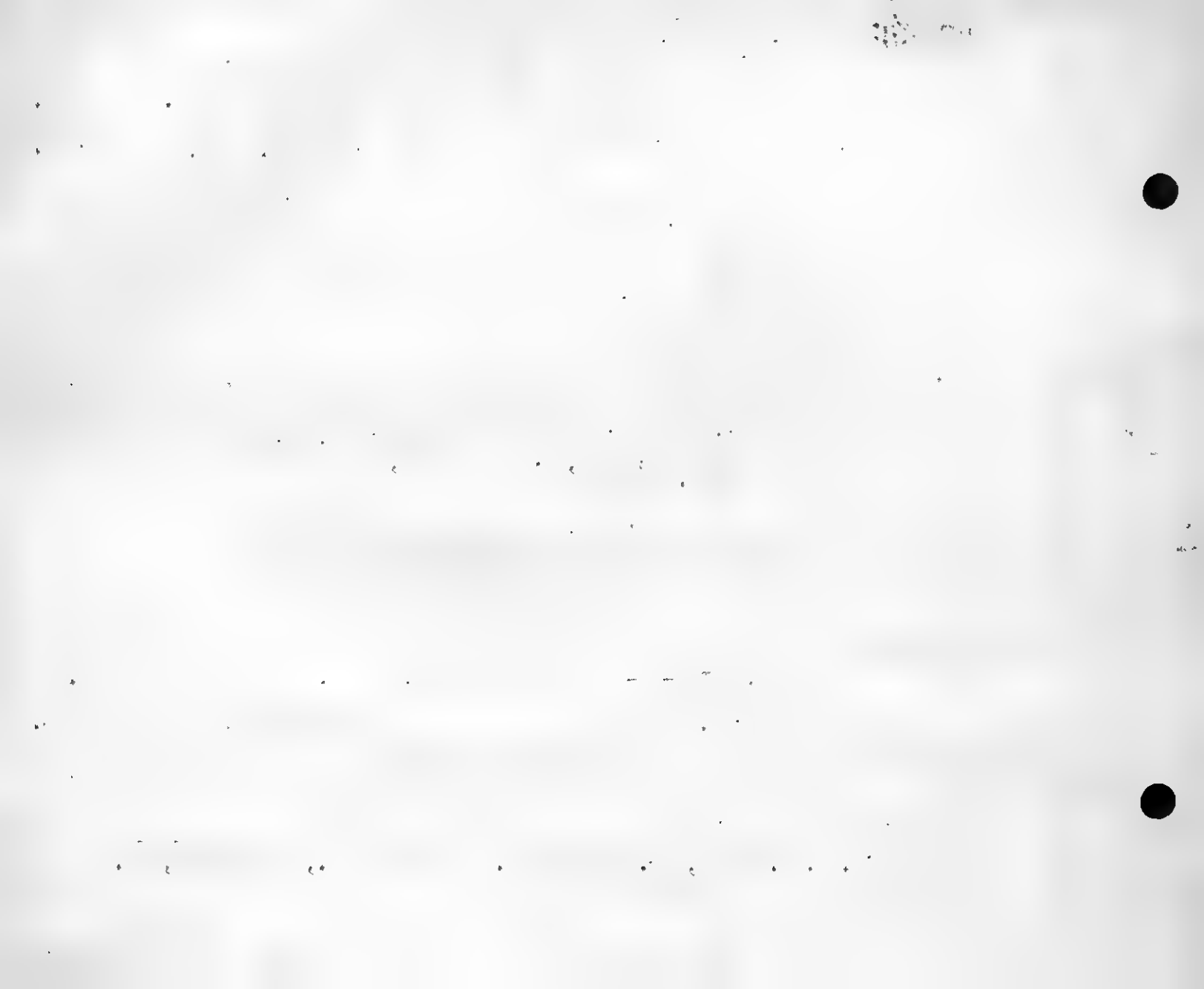
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15142 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <b>IRA</b>			First Middle Last <b>R. FOX</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day <b>68</b> <b>2:48</b>		2b. HOUR		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>May 23, 1905</b>	6 AGE (n years last birthday) <b>63</b> YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>Aug. 21, 1968</b> <b>2:48</b>		
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CIT ZEN OF WHAT COUNTRY? <b>USA.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Orchard</b>		
13a. USUAL RES.DENCE (Where deceased lived if institution Residence before admission) STATE <b>Penna.</b>			13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Waynesboro</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RDA 2</b>	
14. FATHER'S NAME First Middle Last <b>Martin FOX</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Hartman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>192-32-8989</b>		17 INFORMANT ADDRESS <b>Elmer H. Fox 246 S. Main St. Chambersburg, Pa.</b>					
18 CAUSE OF DEATH (Enter on any one cause per line for (a) (b) and (c)) <b>Shock Following Crushing Injury Of</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Therax With Multiple Rib Fractures, Fracture Of</b>								<b>4 1/2 hours</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Left Clavicle, Right Scapula, And Sternum</b>										
(b) <b>Pneumothorax, Right</b>										
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Laceration Of Right Lung (Rib Fractures)</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9121</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>10:15 AM 8-21-1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) <b>Pinned beneath over turned farm tractor.</b>						
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Hess Bros. Orchard</b>		21f. LOCATION Street or R.F.D. No. <b>Waynesboro,</b>		City or Town County State <b>Pa.</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>A. W. Ditto, Jr.</b>		EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22b. DATE SIGNED <b>8-22-68</b>		22c. ADDRESS (Street, City, Town, or County) <b>215 W. Washington St., Hagerstown, Md.</b>				
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brown's Mill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Franklin Penna</b>				
24. FUNERAL DIRECTOR <b>John O. Park</b>				ADDRESS <b>Chambersburg, Penna</b>		25a. REC'D BY REGISTRAR <b>Aug 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12150 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Paul Charles Fredericks						August 25 1968			M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
Male	White		June 11, 1896			72 YRS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Pottsville, Pa.			USA				Washington Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington County Hospital			Manager		Hotels	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Washington		Hagerstown				53 Wayside Ave.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles Henry Fredericks			Elmira Nuss						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
N			205-09-7269		P.C. Fredericks (3/28/67)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/8</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201 Diabetes</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/22/1959</u> , to <u>8/24/1968</u> , that (I) (we) last saw the deceased alive on <u>8/24/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		22e. DATE SIGNED	
<u>Howard N. Weeks M.D.</u>			Howard N. Weeks, M. D.			580 Northern Ave., Hagerstown,		<u>8/26/68</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			8/28/68		Pleasant View Cemetery		Sinking Spring-Berks-Penna.		
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>						25a. REC'D BY REG. STRAR DATE		25b. REGISTRAR'S SIGNATURE	
Rest Haven Funeral Chapel Hagerstown, Md.						AUG 29 1968		<u>Charles Judge</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12151 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
Keiva Jeanette Gaines						ESTIMATED <input checked="" type="checkbox"/> Month Day Year			4 P M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR
Female	Colored	June 6 1968	YRS 2	MONTHS 15	DAYS 15	Aug. 20, 1968			3:55 P. M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Hagerstown Md		USA				Washington			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown Md		Washington County Hosp.							
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Washington			Hagerstown				225 1/2 N. Jonathan St.,		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Unknown			Judith Gaines						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
					Judith Gaines				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malnutrition</u>									10 weeks
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
7720									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
			HOUR A M P M 19						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>A. E. W. Ditte, Jr.</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditte, Jr.</u>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			Aug. 21, 1968			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			ADDRESS (Street, city, town, or county)						
			215 W. Washington St., Hagerstown, Md.						
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		County	State
Burial		8-22-1968		Rose Hill Cemetery		Hagerstown Md		Wash.	
24 FUNERAL DIRECTOR ADDRESS			25a RECD BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
<u>John R. Watson Jr. Hagerstown Md.</u>			DATE AUG 26 1968			<u>Charles Judge</u>			

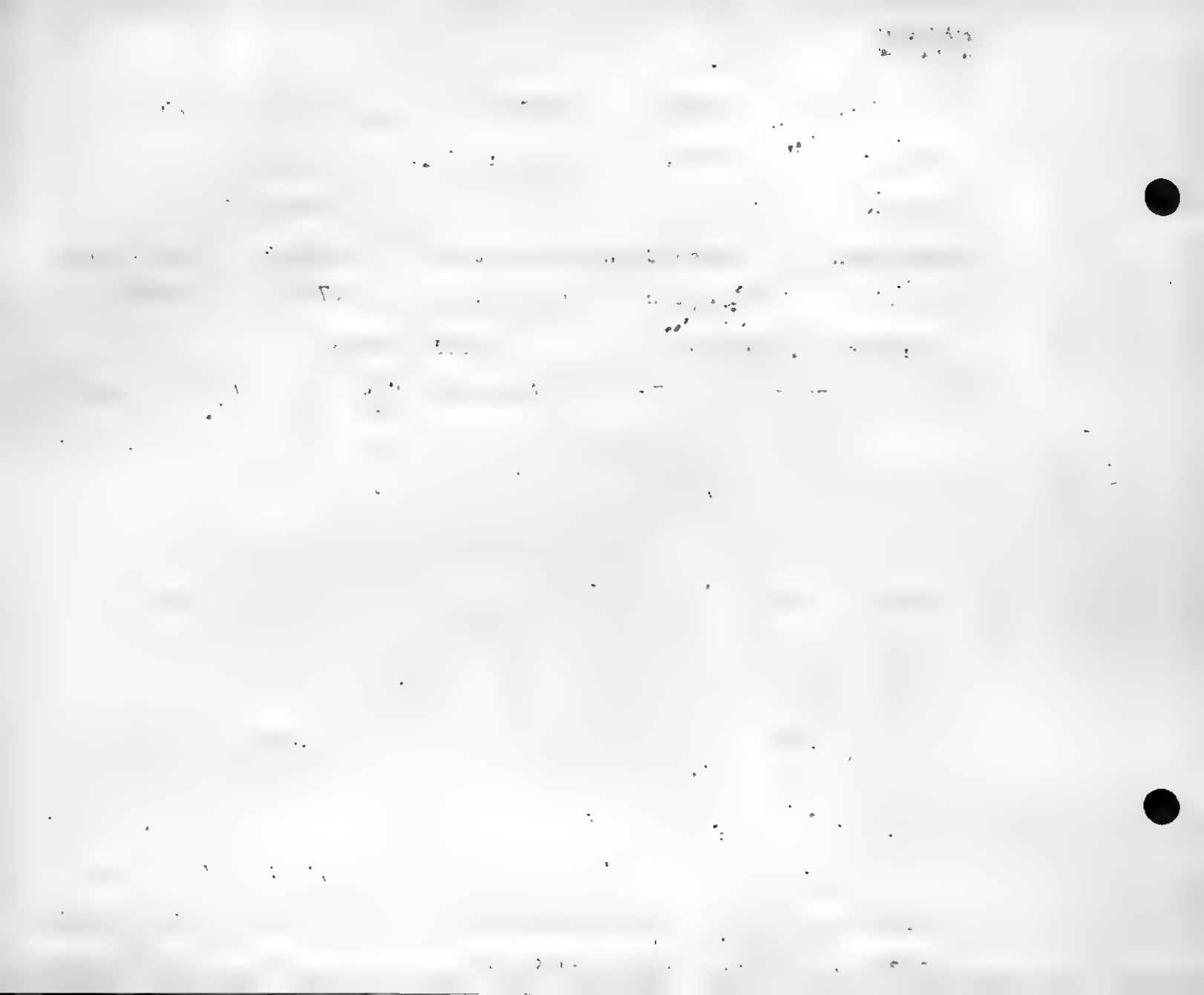


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VR A15 (4)  
30M REV. 1/68

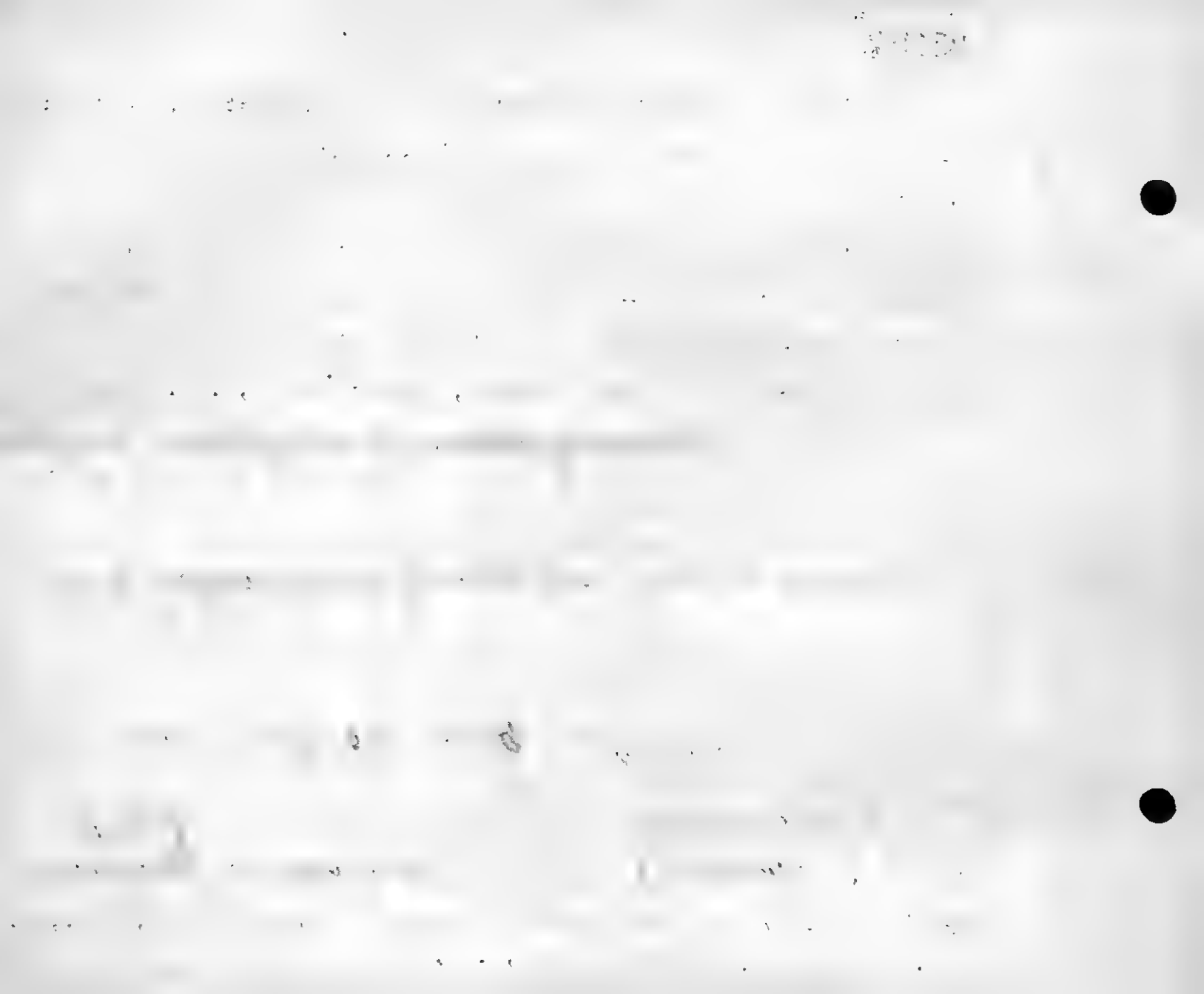
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10-162			
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <b>NORA FRANCES HAMMOND</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>9 PM</b>	
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 3 1894</b>		6 AGE (In years last birthday) <b>74</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housework</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before address on) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1808 The Terrace</b>	
14. FATHER'S NAME First Middle Last <b>Charles E. Hammond</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Effie Bowers</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-22-9467</b>		17. INFORMANT Address <b>Mrs Mabel Updegrove 1708 The Terrace Hagerstown Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Auricular fibrillation?</b> DUE TO, OR AS A CONSEQUENCE OF, (c) <b></b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>11</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>none</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <b>Aug 10, 1968</b> , to <b>Aug 15, 1968</b> , that (1) (we) last saw the deceased alive on <b>Aug 15, 1968</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>M.E. Byrkit M.D.</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Aug 17, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>M.E. Byrkit</b>				22e. ADDRESS <b>Williamsport Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/19/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>				25a. REC'D BY REGISTRAR <b>AUG 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
12153 CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>JAMES ALFRED HANES</b>						2a. DATE OF DEATH Month Day Year <b>August 24, 1968</b>			2b. HOUR <b>8:30</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 30, 1890</b>			6. AGE (In years lost birthday) <b>78</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.						
10. CITY OR TOWN OF DEATH <b>Samples Manor</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Residence</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Samples Manor</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>John Brown Farm Road</b>		
14. FATHER'S NAME First Middle Last <b>Christopher Columbus Hanes</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Kathryn Anne Myers</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Austin E. Hanes</b> Address <b>RFD# 1, Harpers Ferry, W. Va. 25425</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary fibrosis and emphysema</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>more than a year</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>25x atherosclerosis and disability with coronary heart</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CARRYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>6/12</b> , 19 <b>66</b> , to <b>7/8</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>7/8/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>C. Amabile</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/26/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>R. Amabile</b>						22e. ADDRESS <b>120 W Main ST Harpersburg</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Samples Manor, Wash., Md.</b>					
24. FUNERAL DIRECTOR <b>Alfred Eckles</b>		ADDRESS <b>Harpers Ferry, W. Va.</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Jones</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10153 CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <b>Howell Chester Happ</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>3:00A</b> M					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 7, 1903</b>		6 AGE (In years last birthday) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>2</b>		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Deweyville, Texas</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Washington</b> Md.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Attorney</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Gapland</b>		13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rfd.</b>	
14 FATHER'S NAME First <b>John</b> Middle <b>Happ</b> Last <b>Happ</b>			15 MOTHER'S MAIDEN NAME First <b>Dora</b> Middle <b>Collier</b> Last <b>Collier</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No.</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>463-24-8645</b>			17 INFORMANT Address <b>Mrs. Marjorie Happ, Gapland, Maryland</b>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Condit trans, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis with coronary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>about 3 hr</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		at 3 hr 8/9/68					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/9</b> , 19 <b>68</b> , to <b>death</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/9/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R. Amarillo</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>8/9/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>R. Amarillo</b>				22e. ADDRESS <b>Sharpsburg, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Wash. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>						25a. REC'D BY REG-STRAR <b>AUG 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

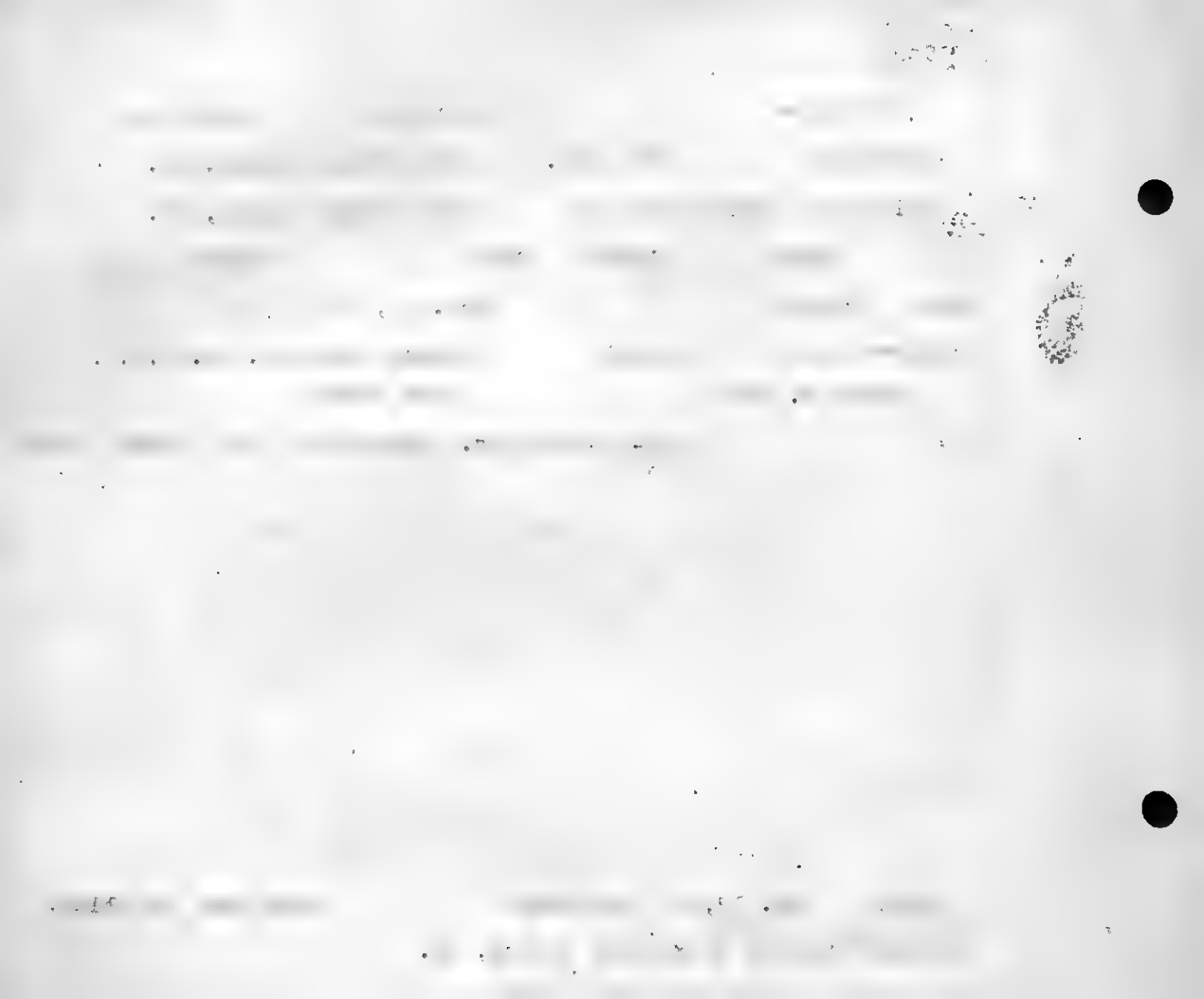


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>TWO MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b. <b>Two Hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RFD-1 Clear Spring, Md.</b> d. STREET ADDRESS <b>RFD-1 Clear Spring, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>Clyde Wilbur Hart</b> First Middle Last <b>4. DATE OF DEATH</b> <b>August 10 1968</b> Month Day Year			<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Oct. 15, 1913</b> 9. AGE (in years last birthday) <b>54</b> yrs.						
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Delivery man</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Florist</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Morgan County W. Va.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			<b>13. FATHER'S NAME</b> <b>Arthur G. Hart</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Beard</b>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <b>214-16-0694</b> <b>17. INFORMANT</b> <b>Mrs. Alice Hart</b> Address <b>RFD-1 Clear Spring</b>						
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>Arteriosclerosis, General</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>42.1</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 hrs.</b> <b>not known</b>				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town) (County) (State)</b>						
<b>21. I certify that (I) (this hospital) attended the deceased from Feb. 1968 to Aug. 10, 1968, that (I) (we) last saw the deceased alive on Aug. 10, 1968, and that death occurred at 2:00 P.M. from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>[Signature]</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Arturo Riego</b> <b>22d. ADDRESS</b> <b>119 E. Annapolis St.</b>					<b>22b. DATE SIGNED</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Aug. 13, 68</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Shanktown</b> <b>23d. LOCATION (City, town or county) (State)</b> <b>Shanktown Maryland</b>			<b>24. FUNERAL DIRECTOR</b> <b>Edmond E. Thompson</b> ADDRESS <b>Thompson Funeral Home Clear Spring, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>AUG 15 1968</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>						



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1166

1 DECEASED NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR
Mabel Geraldine				Hawn	Aug. 25			1968		M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year
Female	White	March 11, 1928		46	5 13	Month		Day	Year	19
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2d HOUR			
Maryland	USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington		2:30 P.M.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Hagerstown		DOA Washington Co. Hosp.		Housewife						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.F.D. #2		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
Wilbur				Kendall	Mamie					Snyder
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS				
No		215-42-3932		Mrs. Wilbur Kendall		Smithsburg, Md.		RFD #2		
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										hours
348X DUE TO, OR AS A CONSEQUENCE OF										
Congestive failure										
(b) DUE TO, OR AS A CONSEQUENCE OF										Yrs
Rheumatic Heart disease										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
416X										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b DATE SIGNED						
Howard N. Weeks, M.D.				8/27/68						
23a. BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		County		State
Burial		Aug. 28, '68		Rest Haven Cemetery		Hagerstown, Wash., Maryland				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Albert L. Leaf		Williamsport, Md.		DATE AUG 29 1968		James Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12157 CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <b>LEAH H. HEGE</b>					2a. DATE OF DEATH <b>Aug</b> Month <b>1</b> Day <b>1968</b>			2b. HOUR <b>9:20 P.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>5/13/1890</b>			6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Wash. Co., Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OR DEATH <b>Clearspring, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Clearspring, Md.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>-</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rd 1 - Clearspring, Md.</b>	
14. FATHER'S NAME First Middle Last <b>John W. Martin</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Amanda Horst</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Rd 1 -</b> Address <b>Henry Hege Clearspring, Md.</b>					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno Carcinoma Colon</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY; OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 5, 1968</b> , to <b>Aug. 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>7-29-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.										
22b. SIGNATURE <b>A. E. W. Ditto, Jr.</b>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 2, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>					22e. ADDRESS <b>215 W. Washington St., Hagerstown, Md.</b>					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <b>8/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reiff Ch. Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>near Coarloss, Md.</b>			
24. FUNERAL DIRECTOR <b>A. E. Munnich - Greencastle, Penna.</b>					25a. REC'D BY REGISTRAR <b>AUG 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12158  
CERTIFICATE OF DEATH

1168

1. DECEASED-NAME (Type or print) <b>HARRY</b>			First Middle Last <b>ELMER</b> <b>HOUSE</b>			2a. DATE OF DEATH Month Day Year <b>August 15, 1968</b>			2b. HOUR <b>9:05 P.</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>August 28, 1889</b>			6. AGE (in years last birthday) <b>78</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Middletown, Rt. 1</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington</b> Md.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Middletown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Charles</b> <b>House</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Katie</b> <b>Moser</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-36-0118</b>			17. INFORMANT Address <b>Mrs. Mary House, Rt. # 1, Middletown, Md.</b>					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiac Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 day</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4241</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 10, 1968</b> , to <b>Aug 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. W. LeVan</b>						22c. DATE SIGNED <b>Aug 16, 1968</b>			22d. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>		
22e. ADDRESS <b>Boonsboro, Md.</b>											
23a. BURIAL CREMATION, REBURNING (Specify) <b>Burial</b>			23b. DATE <b>8-18-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Wash. Co., Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>AUG 20 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1977



1977



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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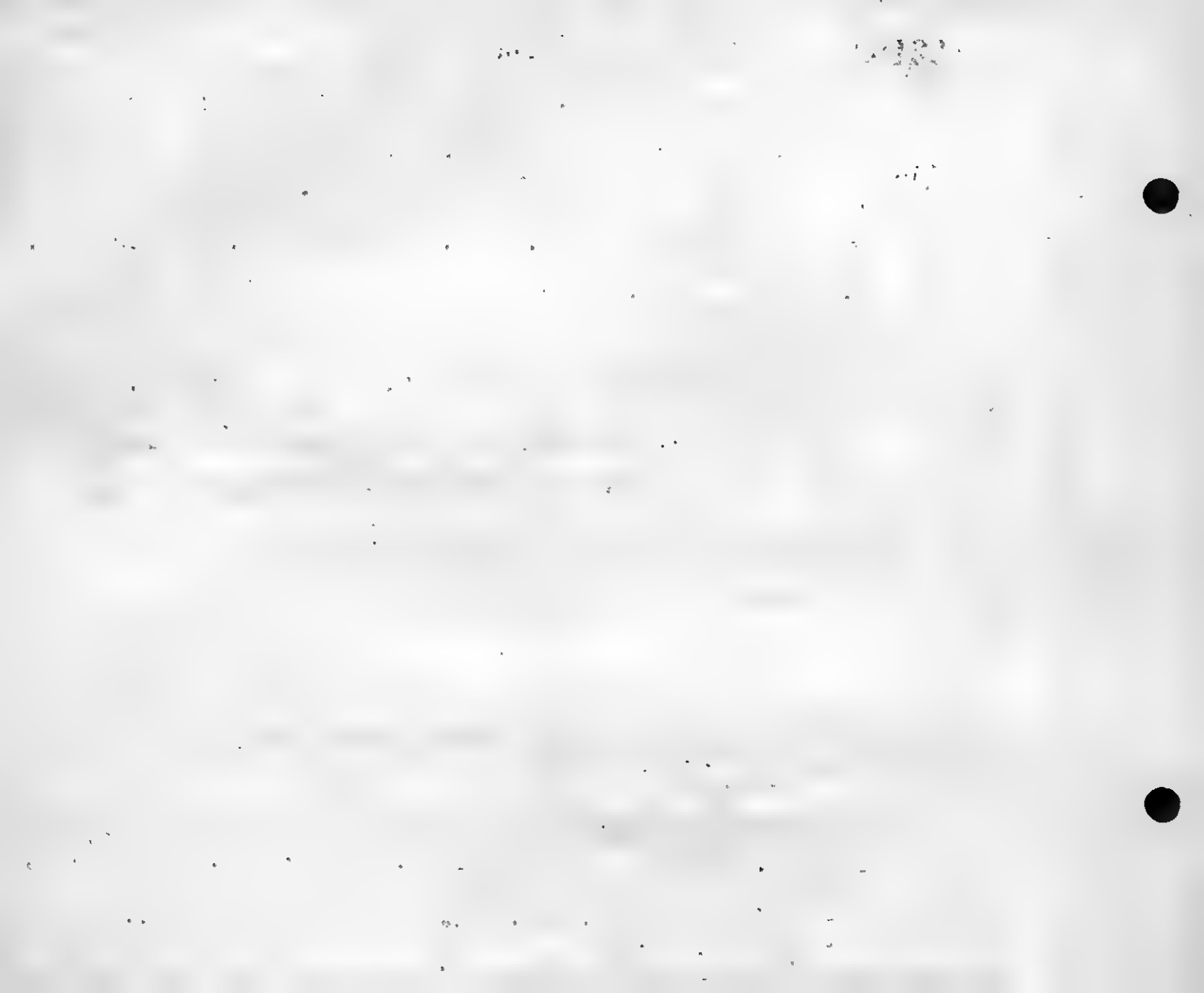
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12159

CERTIFICATE OF DEATH

12169

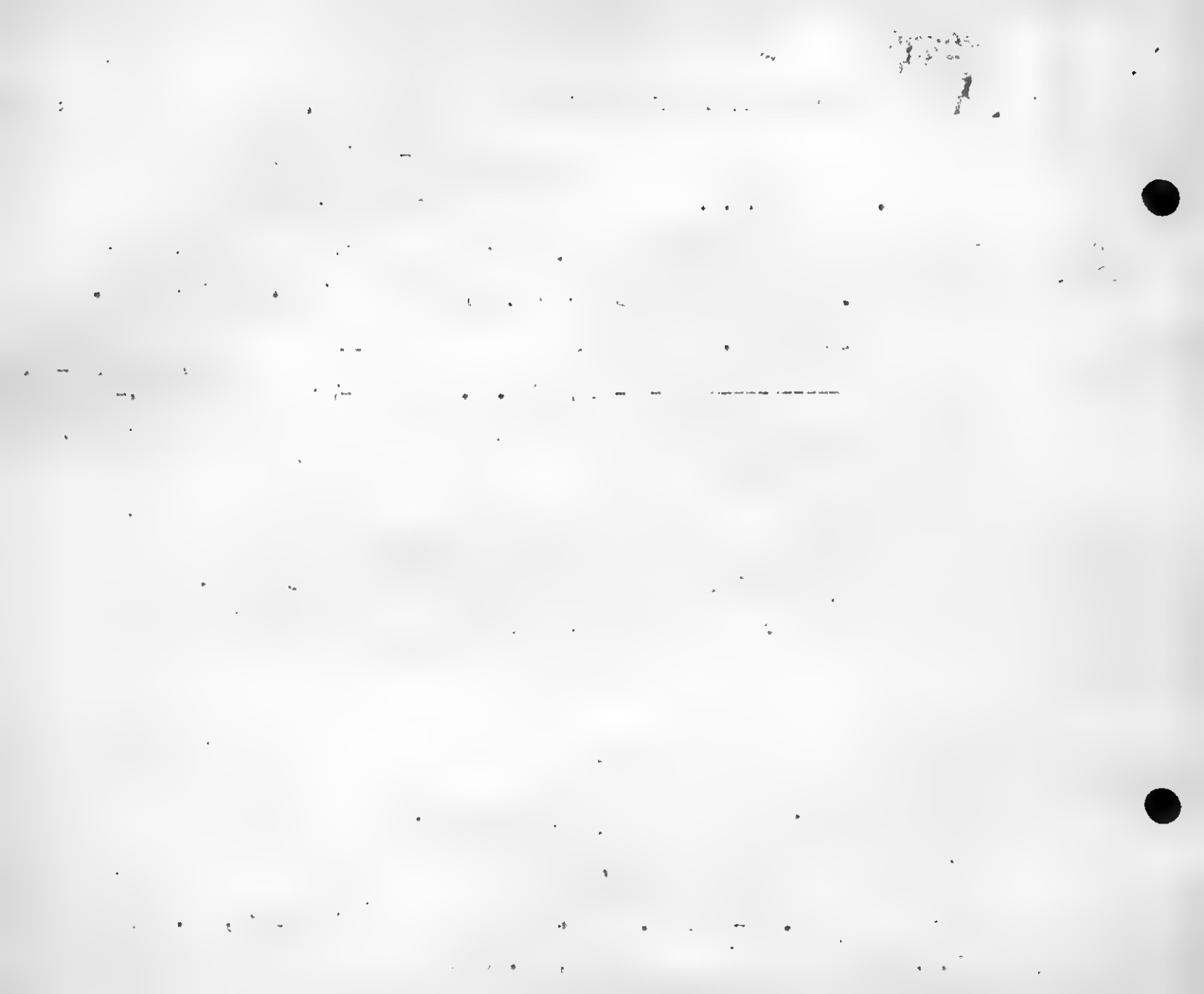
1. DECEASED NAME (Type or print) First Middle Last Russell Paul Howe Sr.			2a. DATE OF DEATH Month Day Year Aug. 27 1968		2b. HOUR 10:00
3. SEX male	4. RACE white	5. DATE OF BIRTH Oct. 25, 1894		6. AGE (In years lost birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Motor Op.	12b. KIND OF BUSINESS OR INDUSTRY Own Bus.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Fred.	13c. CITY OR TOWN Lantz	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RD 1	
14. FATHER'S NAME First Middle Last Jacob Howe			15. MOTHER'S MAIDEN NAME First Middle Last Anna Snively		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 175-03-4385		17. INFORMANT Address Bessie G. Howe Lantz, Md. RD 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>many years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>many years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/22, 1968</u> to <u>8/27, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edson B. Moody</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Aug 27, 1968</u>	
22d. PHYSICIAN'S NAME (Type) Edson B. Moody		22e. ADDRESS 115 S. Prospect St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-30-68	23c. NAME OF CEMETERY OR CREMATORY Phila. Mem. Park Cem.		23d. LOCATION (City or Town) (County) (State) Wilmington, Del.	
24. FUNERAL DIRECTOR <u>Raymond E. Cressler</u>		ADDRESS <u>Thurmont, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 30 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
10160 CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
George William Smith Hunichen						Aug. Month 24 Day 68 Year		4:30 P		
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS		
Male		White		August 6- 1897		71 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
Md.		U.S.A.				Washington		Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co. Hospital			Furniture Refinisher		Retired		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21 W. Washington St.	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Albert S. Hunichen			Ida Smith							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
No			215-20-9157		Geo. A. Hunichen-7 South French St.- Alexandria-Va.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u>									1 yr.	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>General Metastases of Carcinoma</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
1968		Carcinoma of Esophagus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year		None						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 68</u> to <u>Aug 23 19 68</u> , that (I) (we) last saw the deceased alive on <u>Aug 23 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>J.H. Beachley</u>								8/24/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
<u>J.H. Beachley</u>				<u>Hagerstown, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Aug. 28-1968		Mt. Olivet Cemetery		Frederick, Md. 21701				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>Elwood T. M.R. Etchison &amp; Son</u>				<u>Frederick, Md. 21701</u>		DATE <u>AUG 28 1968</u>		<u>Charles Judge</u>		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

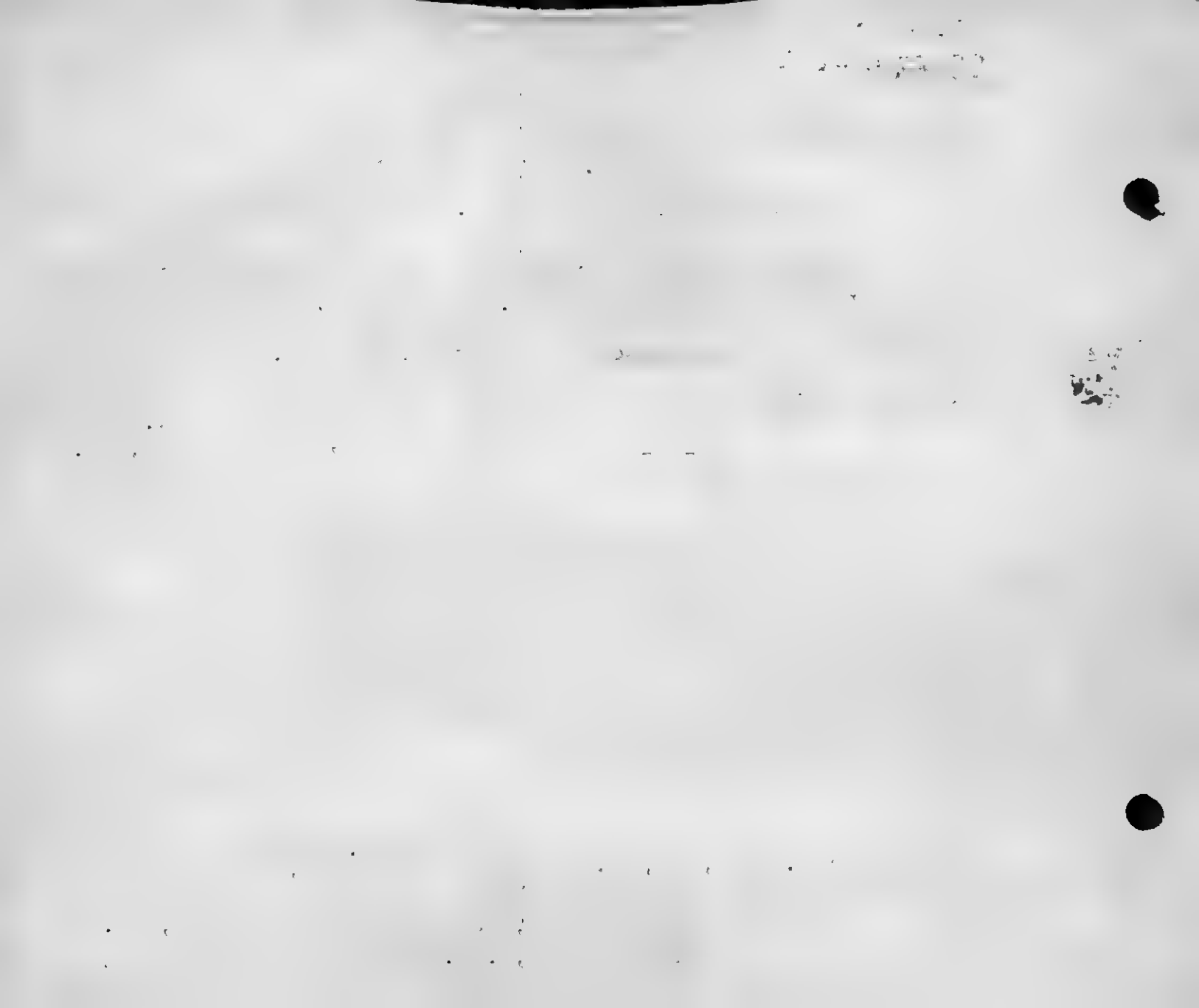
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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Martin Manor Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b> d. STREET ADDRESS <b>211 W. Antietam Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AGNES SAVILLA JAMISON</b>		4. DATE OF DEATH <b>August 23, 1968</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Bakerton, West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Ingram</b>		14. MOTHER'S MAIDEN NAME <b>Anna Gertrude Welsh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-34-3863</b>	
17. INFORMANT <b>Thurman Jamison, Sharpsburg, Md.</b>		Address <b>211 W. Antietam St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> DUE TO <b>Acute Intestinal Obstruction, incarcerated Umbilical Hernia</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>12 hr.</b> DUE TO <b>24-36 hr.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b> <b>24-36 hr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 3, 1966</b> to <b>Aug. 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 27, 1968</b> , and that death occurred at <b>2:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b>		22b. DATE SIGNED <b>8/24/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto, III, MD.</b>		22d. ADDRESS <b>217 W. Washington Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/26/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor, Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Samples Manor, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Donald Eckel</b>		25a. REC'D BY REGISTRAR <b>AUG 26 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
10162  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>CHARLES EARL KAETZEL</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>355 P M</b>
3 SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>10-18-1892</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b>		
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) <b>Moulder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sand Blast Equip</b>
13a. USUAL RES DENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Chewsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Box 27</b>
14. FATHER'S NAME First Middle Last <b>Lewis P. Kaetzel</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Laura Fouch</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-09-6030A</b>		17. INFORMANT Address <b>Mrs. Marion R. Kaetzel Chewsville, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> , 19 <b>66</b> , to <b>8-24</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-24</b> , 19 <b>68</b> , and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Domingo A. Garcia</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>August 24, 1968</b>
22d. PHYSICIAN'S NAME (Type) <b>DOMINGO A. GARCIA</b>				22e. ADDRESS <b>WESTERN MARYLAND STATE HOSPITAL</b>		
23a. BURIAL, CREMATION, REMOVA, (Specify) <b>Burial</b>		23b. DATE <b>8-27-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

1900

1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>Lulu Mar Kaylor</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>4:15</b> PM					
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>JULY 25, 1885</b>		6 AGE (In years last birthday) <b>83</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>WASHINGTON</b> Md.					
10 CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>HOMEMAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>433 N. POTOMAC STREET</b>	
14 FATHER'S NAME First Middle Last <b>ALAN DENTON EAKLE</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>LAURA MIDDLEKAUFF</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>----</b>		17 INFORMANT <b>433 Address N POTOMAC ST. HAGERSTOWN, MARYLAND</b> <b>MR. HARRY W KAYLOR</b>						
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>7-22, 1968</b> , to <b>8-24, 1968</b> , that (I) (we) last saw the deceased alive on <b>8-24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Domingo A. Garcia</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>August 24, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>DOMINGO A. GARCIA</b>						22e. ADDRESS <b>WESTERN MARYLAND STATE HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>8/27/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASHINGTON MD.</b>		
24. FUNERAL DIRECTOR <b>Charles M. Renger</b> HAGERSTOWN, MARYLAND						25a. REC'D BY REGISTRAR DATE <b>AUG 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



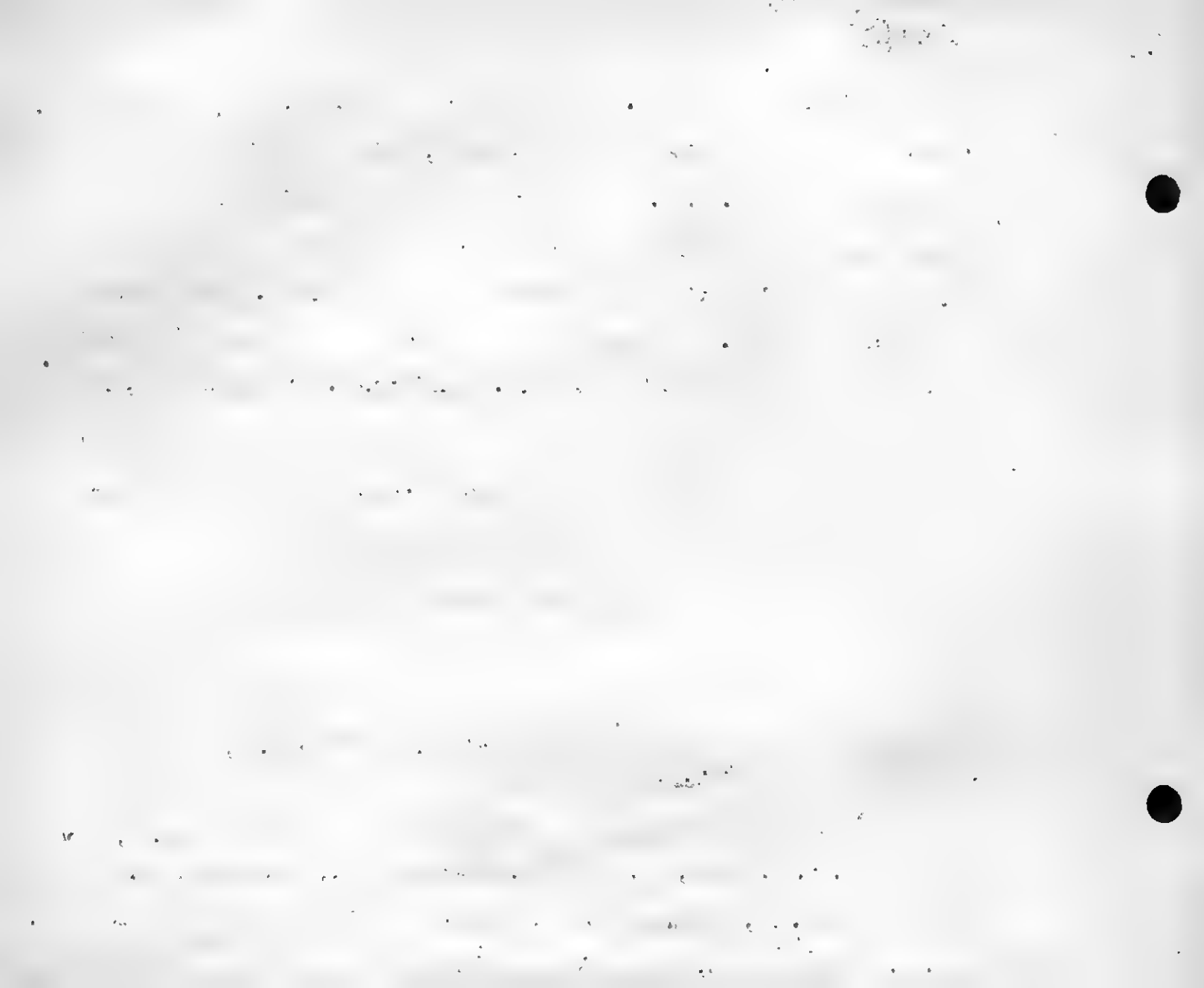
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove/carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

174

1. DECEASED-NAME (Type or print) First <b>Lillie</b> Middle <b>I.</b> Last <b>Keefer</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1968</b>		2b. HOUR <b>2:50</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>June 29, 1875</b>		6. AGE (in years last birthday) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Washington</b> Md.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Martin Manor Nursing Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. US. AL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>412 W. Second Street</b>	
14. FATHER'S NAME First <b>George</b> Middle <b>W.</b> Last <b>Smith</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Jane</b> Last <b>Burrier</b> Md.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO <b>220 48 3926</b>	17. INFORMANT Address <b>Mrs. John Renn, Jr. 309 Fleming Ave, Frederick</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 day's</b> <b>5 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1967</b> , to <b>Aug. 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug. 8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (view) the body after death					
22b. SIGNATURE <i>E. W. Ditto, Jr.</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>Aug. 9, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>	22e. ADDRESS <b>215 W. Washington St., Hagerstown, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 12, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Frederick Frederick Md.</b>		
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	25a. REC'D BY REGISTRAR <b>AUG 13 1968</b>	25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last <b>HANNAH ELIZABETH KELLEY</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8/6/1968 MATED <input type="checkbox"/>		2b. DATE OF DEATH ESTIMATED <input type="checkbox"/> 8/6/1968 MATED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 8/6/68 Day 19 Year 9:30 PM	
3 SEX <b>F</b>	4 RACE <b>W</b>	5. DATE OF BIRTH <b>4/2/1887</b>	6 AGE (in years and birthday) <b>81</b> YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					
7a BIRTHPLACE (State or foreign country) <b>TEXAS</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>WASHINGTON</b>					
10 CITY OR TOWN OF DEATH <b>HAGERSTOWN, MD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON COUNTY</b>			12a. USUAL OCCUPATION (Kind of work done during past working life, even if retired) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>			13b COUNTY <b>WASHINGTON</b>			13c CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER	
14 FATHER'S NAME First Middle Last <b>GEORGE WEAVER</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>DORA MARTIN</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b SOCIAL SECURITY NO <b>293-14-7148</b>			17. INFORMANT <b>ADD HAGERSTOWN, MD. A ELSIE B KERSHNER 70 DEVONSHIRE RD.</b>					
18 CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>331X</b> (b) <b>Arteriosclerotic disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>Years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Nephrosclerosis with uremia &amp; fracture of left hip.</b>											
19a. DATE OF OPERATION <b>8/2/68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture of left hip.</b>			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>2:10 P.M. 7/30/68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Patient fell out of wheel chair</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm street, factory, office building, etc.) <b>Coffman Home for the Aging, Pennsylvania Avenue</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>Hagerstown, Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Howard N. Weeks</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>8/7/68</b>		
EXAMINER'S NAME (Type) <b>Howard N. Weeks, M. D., Hagerstown, Maryland</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL (Cremation, entombment) <b>8/9/68</b>			23b. DATE <b>8/9/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>TONOLOWAY BAPTIST RURAL HANCOCK FULTON PA.</b>			23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Maryland</b>		
24. FUNERAL DIRECTOR <b>Howard F. Moore Hancock Md</b>						25a. REC'D BY REGISTRAR <b>DATE AUG 15 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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CERTIFICATE OF DEATH

12176

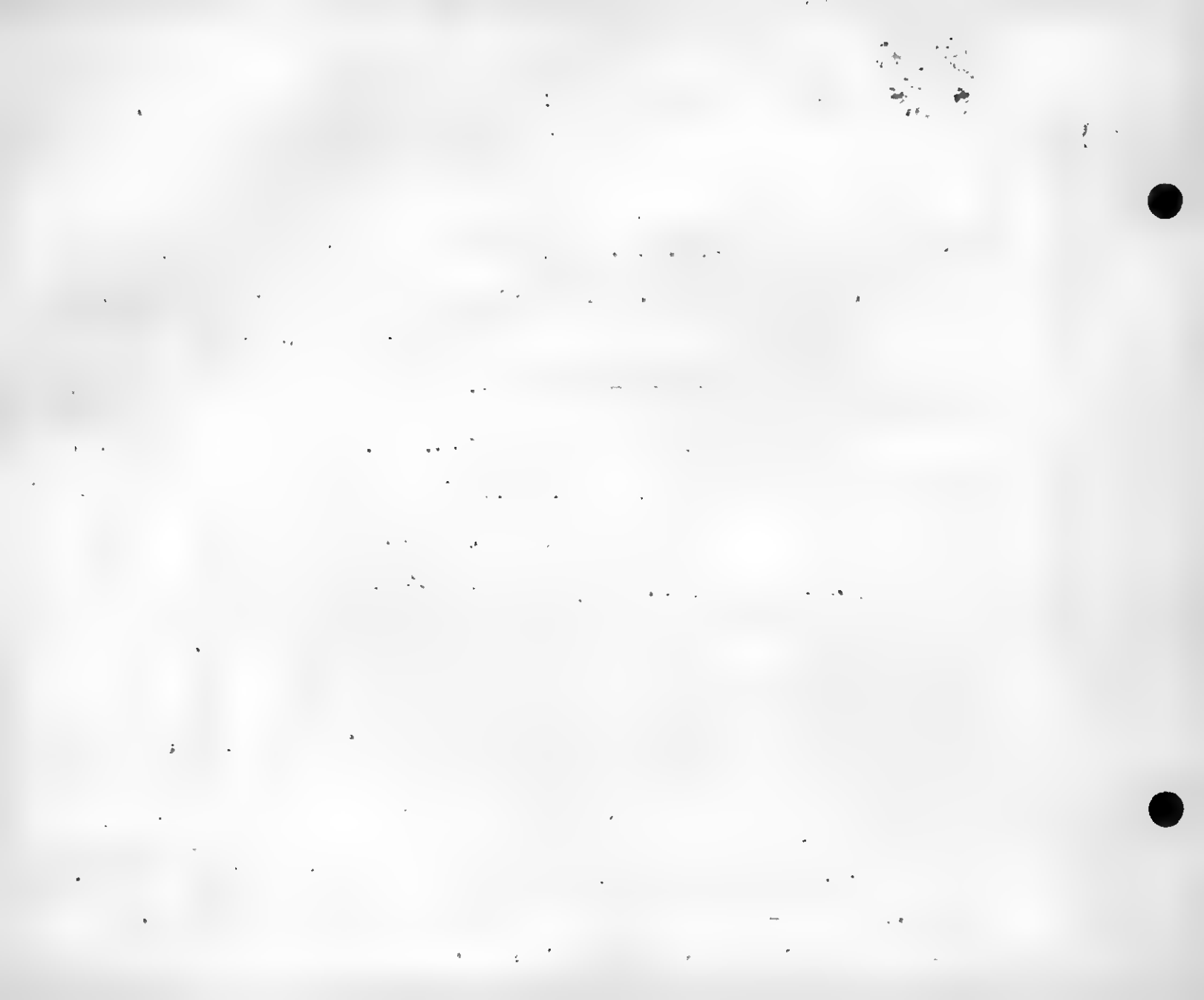
12165

1 DECEASED NAME (Type or print) <b>John August Kern</b>			2a DATE OF DEATH <b>August 30, 1968</b>			2b HOUR M			
3 SEX <b>male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH <b>Aug. 16, 1894</b>		6 AGE (in years last birthday) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>		12a USUAL OCCUPATION (Kind of work done during past 5 years, include even if retired) <b>pipe fitter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>Wash.</b>		13c CITY OR TOWN <b>Hagerstown</b>		3d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>100 Fairground Ave.</b>	
14 FATHER'S NAME <b>Adam Kern</b>			15. MOTHER'S MAIDEN NAME <b>Frieda Dieringer</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <input checked="" type="checkbox"/> No		16b SOCIAL SECURITY NO <b>705-10-5741</b>		17. INFORMANT Address <b>Mrs. Alice Kern, Hagerstown, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>thrombosis of superior mesenteric artery</b> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>generalized atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>4 yrs</b> <b>3 yrs.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Active pulmonary tuberculosis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/9</b> , 19 <b>65</b> , to <b>8/30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/30</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Donald E. Martin</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>8/31/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DONALD E. MARTIN M.D.</b>		22e ADDRESS <b>363 S. CLEVELAND AVE (WASH) Md</b>							
23a BURIAL, CREMATION, or other final disposition <b>burial</b>		23b. DATE <b>9-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>			
24 FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>				25a REC'D BY REGISTRAR DATE <b>SEP 3 1968</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

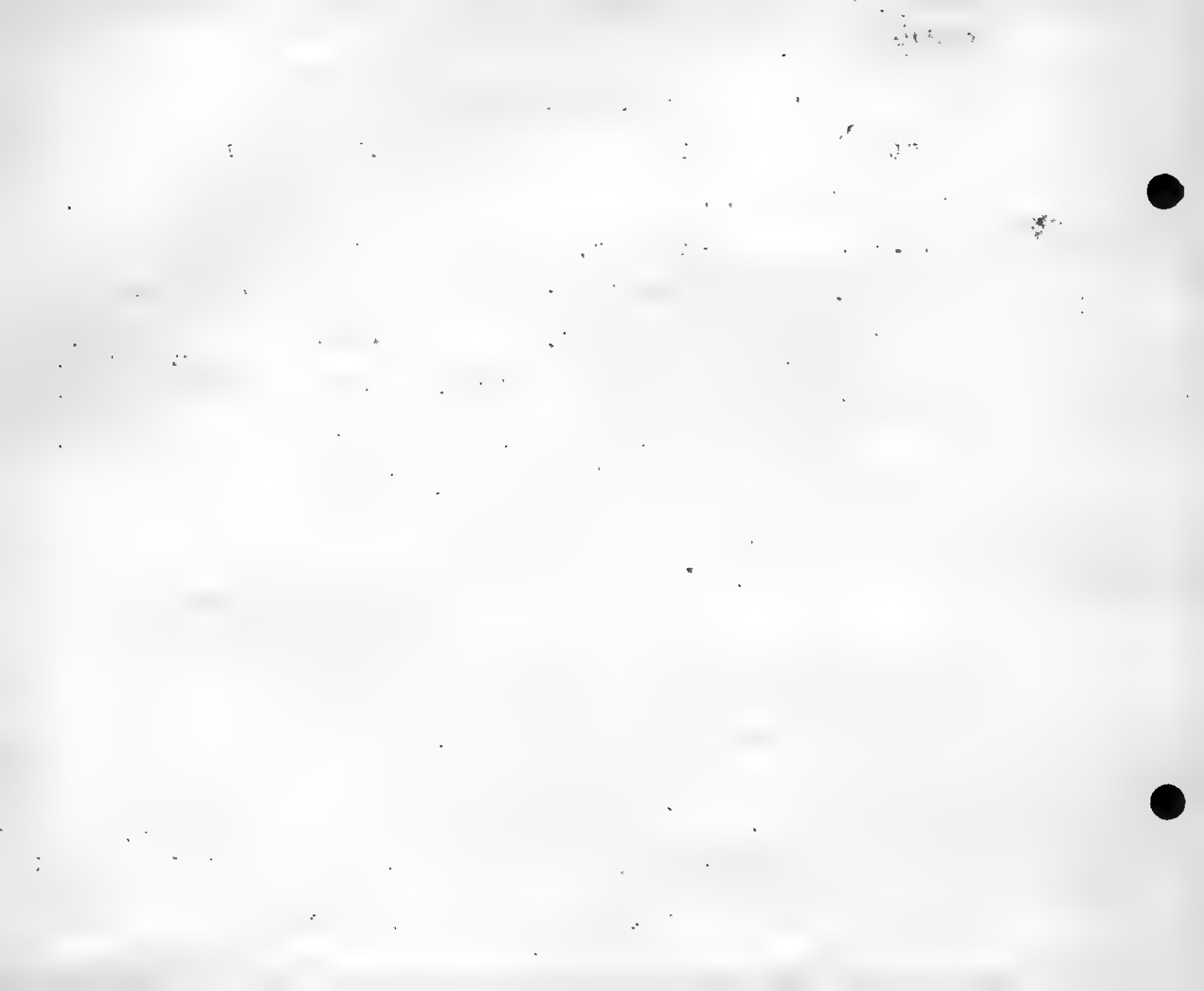
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15167 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
HELEN ELIZABETH LONGENBERGER						Month Day Year AUG 1 1968		3:20A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		JULY 14 1917		51 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				WASHINGTON		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WASHINGTON COUNTY HOSP.		HOMEMAKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		WASHINGTON		HAGERSTOWN				933 SECURITY ROAD	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last CHARLES MOYER SR.			First Middle Last FLORENCE REIFENDIFER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			
NO			NONE			ARTHUR D LONGENBERGER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Ovary</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>abdominal metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>4 wks.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Dehydration &amp; malnutrition</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>February 19 1968</u> to <u>Aug 1, 1968</u> , that (I) (we) saw the deceased alive on <u>July 31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
<u>Edson B Moody M.D.</u>				AUG 3 1968					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
EDSON B MOODY M.D.				363 S CLEVELAND AVE HAGERSTOWN MARYLAND					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
REMOVAL		8/4/68		ST. JOHN'S LUTHERAN CEM.		RINGTOWN PENNA			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Charles M. Ronger</u>				HAGERSTOWN MARYLAND		AUG 5 1968		<u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any deaths occurring on any day of the week, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

B.D.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

178

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF EST. DEATH			Month Day Year			10:25 AM																	
Marvel			Major			8/25/68			19																				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR														
F		W		3/8/1947		21 YRS						Month Day Year			10:25 AM														
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																	
MD.				USA.								Washington				Md.													
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown						Washington CO. Hospital						Beautician																	
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admision) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?						13e. STREET AND NUMBER					
MD.						Alleghany						Lonaconing						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						Florida Way					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																							
Dalton						Major						Shirley						Warnick											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT						ADDRESS											
No												Mrs. Shirley Major, Lonaconing, Md.						(MOTHER)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fat embolus</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last																													
(b) <u>Fracture, femur, left.</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
MEDICAL CERTIFICATION																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?																	
8/24/68						Skin graft						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM.						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
						4:45 PM. 8/24/68						Auto-auto accident																	
21d. INJURY OCCURRED						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No City or Town County State																	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						Hiway						State Rt. #36 at Gilmore, Alleghany, Md.																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE						M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED											
EXAMINER'S NAME (Type)						Howard N. Weeks, M. D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						8/26/68											
												ADDRESS (Street, city, town, or county)																	
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)											
Burial						8/28/1968						Laurel Hill Cemetery						Moscow, Md.											
24. FUNERAL DIRECTOR						ADDRESS						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE											
George Eichhorn						Lonaconing, Md.						DATE AUG 30 1968						Charles J. J...											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

19179

1. DECEASED NAME (Type or print) <b>John ABRAM Marshall</b>			2a. DATE OF DEATH Month <b>8</b> Day <b>23</b> Year <b>68</b>			2b. HOUR <b>7:10 P.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-24-1877</b>		6. AGE (In years lost birthday) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Willis Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			
10. CITY OR TOWN OF DEATH <b>Brownsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fairway-Reedy Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>ELICOTT CITY</b>		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>40 DEERFIELD DRIVE</b>	
14. FATHER'S NAME First <b>El</b> Middle <b>Marshall</b> Last <b>Marshall</b>			15. MOTHER'S MAIDEN NAME First <b>Hannah</b> Middle <b>Weddle</b> Last <b>Weddle</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-24-7595</b>		17. INFORMANT Address <b>MRS LEROY THOMPSON ELLICOTT CITY MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiac vascular disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1968</b> , to <b>Aug 23, 1968</b> , that (I) <del>(we)</del> saw the deceased alive on <b>Aug 23, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.									
22b. SIGNATURE <b>G.W. LeVan M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Aug 23, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>G.W. LeVan M.D.</b>		22e. ADDRESS <b>Brownsville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>AUG 27-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>		23d. LOCATION (City or Town) (County) (State) <b>NEW WINDSOR PERCY MD</b>			
24. FUNERAL DIRECTOR <b>D.D. Hartzler &amp; Sons Union Bridge</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

900000



10170

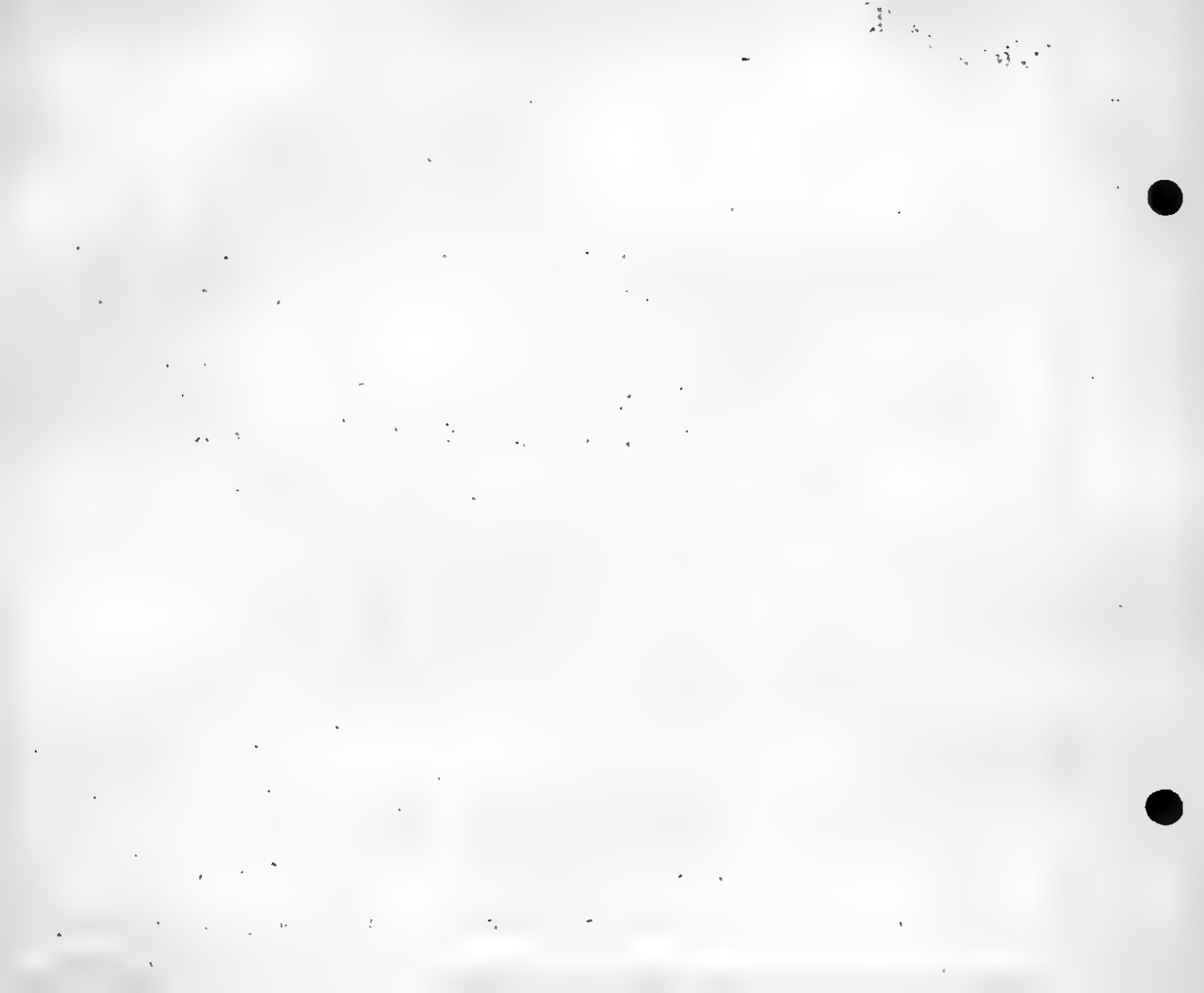
## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>HARRY JAMES MCCARRAHER</b>			2a. DATE OF DEATH Month Day Year <b>AUGUST 5 68</b>			2b. HOUR <b>9:30 A M</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 22, 1898</b>		6. AGE (In years last birthday) <b>70</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>WASHINGTON</b> Md.	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>92 W. WASHINGTON ST.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>ELEVATOR OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>92 W. WASHINGTON ST.</b>		14. FATHER'S NAME First Middle Last <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>UNKNOWN</b>		16b. SOCIAL SECURITY NO. <b>579-01-3607</b>		17. INFORMANT <b>WILLIAM J DWYER</b>		18 N Address <b>JONATHAN ST. HAGERSTOWN, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>							
19a. DATE OF OPERATION <b>4/20/1</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>NO</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>May 16, 1968</b> to <b>August 5, 1968</b> , that (I) (we) last saw the deceased alive on <b>August 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. H. Beckley M.D.</b>		22c. DATE SIGNED <b>Aug 5/68</b>		22d. PHYSICIAN'S NAME (Type) <b>J. H. Beckley</b>			
22e. ADDRESS <b>Hagerstown, Md</b>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>8/8/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASHINGTON MD.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>		ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12171 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Alvey Lee McGowan						August 5 1968			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 MRS.	
Male		White		June 19, 1901		87 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Washington Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital			Laborer			Stone		
13a. U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Dargan		YES		Shinham Road		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
James Albert McGowan				Katie Magdeline Pierce							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT					
No				None		Mrs. Mary H. Gay Address R.F.D. # 1, Harpers Ferry, W. Va. 25425					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular										104	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Cardiac insufficiency										3 wks	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 17, 1968, to Aug 5, 1968, that (I) (we) lost the deceased alive on Aug 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
G. W. LeVan M.D. DEGREE						Aug 6, 1968					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
G. W. LeVan						Boonsboro					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		8/8/68		Samples Manor Cemetery		Samples Manor Wash, Md					
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Donald Eckler		25425		DATE AUG 8 1968		Charles Judge					

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										2182	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR <sup>P</sup> M		
BERNICE LORRAINE MILLER						Aug 14 1968			8 <sup>P</sup> M		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR <sup>P</sup> M
Female	White	Feb 23 1928	40 YRS					Aug 14 1968 19			8 <sup>P</sup> M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Virginia		USA				Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Wash County Hospital			Maid			Motel		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
Maryland			Washington			Hagerstown			427 No Prospect St		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Arthur C. Smallwood			Clara Beale Darnell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			227-30-3445			Frank J. Miller			427 No Prospect St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia + Brain Stem Hemorrhage.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>+ Cerebral edema + Compression.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Subdural Hematoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>15 days</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>7/30/1968</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Apparent Fall in Parking lot</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Parking lot</u>			21f. LOCATION Street or R.F.D. No. City or Town County State <u>Rt. Montgomery Hagerstown Wash Md</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>			EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>8/2/68</u>		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county) <u>217 W. Washington St. Hagerstown, Maryland</u>					
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			8/17/68			Rose Hill Cemetery			Hagerstown Wash Co Md		
24. FUNERAL DIRECTOR Hagerstown Md. ADDRESS Andrew K. Coffman Funeral Home Inc						25a. REC'D BY REGISTRAR DATE AUG 20 1968			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR				
Daisy			May Minnebraker			August 23 1968			M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN		
Female		White		Sept. 9, 1882			85 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
dinburg, Virginia			USA						Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Washington County Hospital			Housewife			Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Washington			Hagerstown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R # 5 Herman Myers Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Emanuel Matthias Coffman			Annie Mdh Mary Barton										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address				
No			220-54-4911			Mr. John N. Minnebraker			R # 5 Hagerstown, Md.				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF <u>nephrosclerosis</u> (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Partial intestinal obstruction, chronic colic, Hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs</u> <u>years</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>16 June 52</u> to <u>late</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>22 Aug 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Richard T. Binford</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>24 Aug 68</u>					
22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M.D.				22e. ADDRESS Hagerstown, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		8/26/68		Rest Haven Cemetery		Hagerstown-Washington-Md.							
24. FUNERAL DIRECTOR <u>Wm. C. West</u>				ADDRESS Rest Haven Funeral Chapel		25a. RECD. BY REG. STRAR DATE <u>AUG 26 1968</u>		25b. REG. STRAR'S SIGNATURE <u>James J. Jones</u>					
				Hagerstown, Md.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

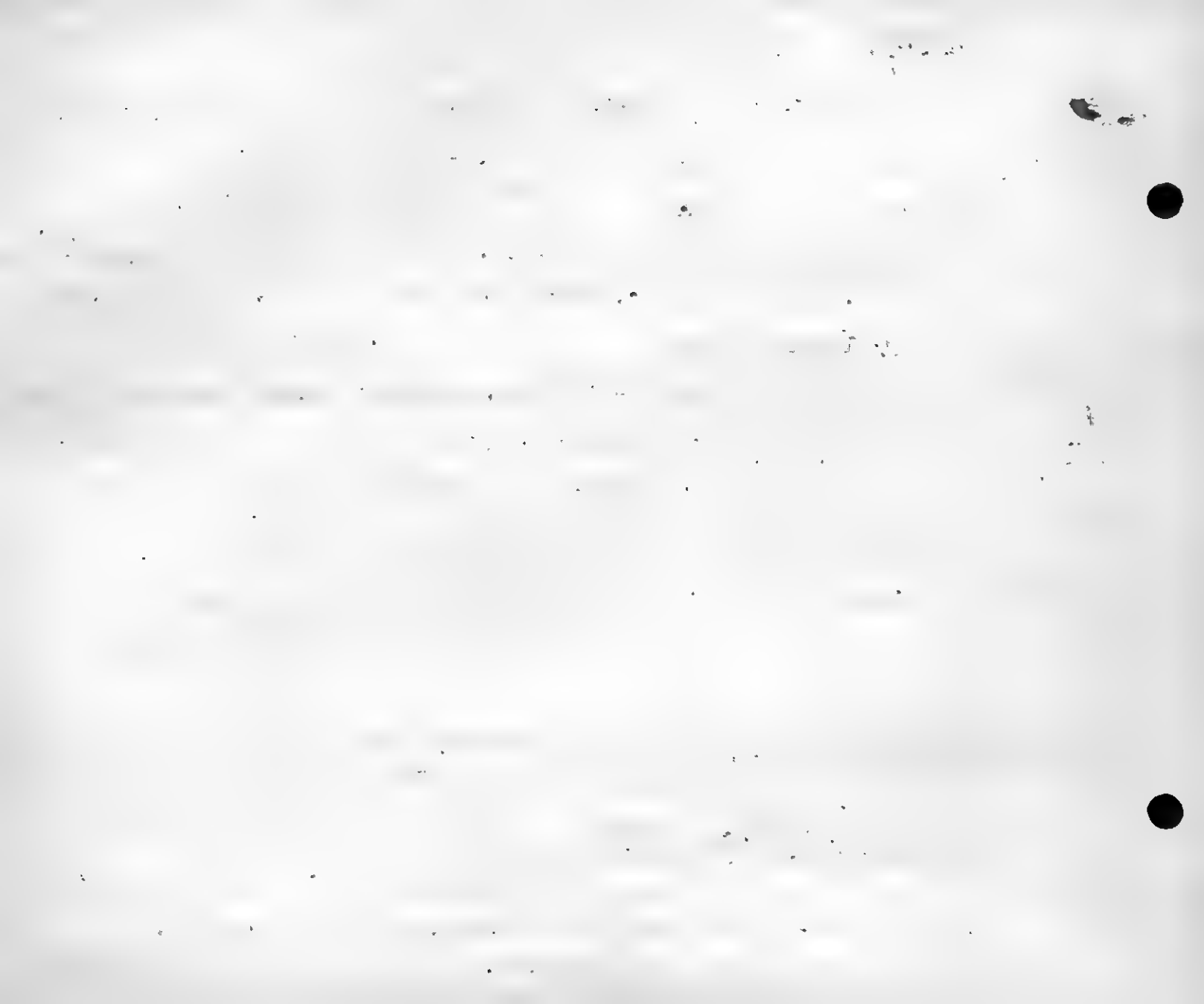
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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
10174  
CERTIFICATE OF DEATH

134

1. DECEASED-NAME (Type or print) <b>Frederick Clinton Mongan</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>8:30</b> P M			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>12-7-1896</b>		6. AGE (In years lost birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>911 Spruce, St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Fabrication</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wash. Hagerstown</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>911 Spruce, St.</b>	
14. FATHER'S NAME First <b>Clinton</b> Middle <b>Mongan</b> Last			15. MOTHER'S MAIDEN NAME First <b>E Stella</b> Middle <b>Mongan</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO (If yes give year or dates of service) <b>214-09-3279</b>		17. INFORMANT Address <b>Mrs. Katherine Mongan Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>Hypertensive and Atherosclerotic Heart</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15-20 mins</b> <b>5 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema; Chronic Bronchitis; Hydrocele Right.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1968</b> to <b>Aug 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 7, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William T. Layman, M.D.</b>		DEGREE <b>William T. Layman, M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Aug 9 1968</b>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>100 Prof Arts Bldg. Hagerstown, Md. 21740</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

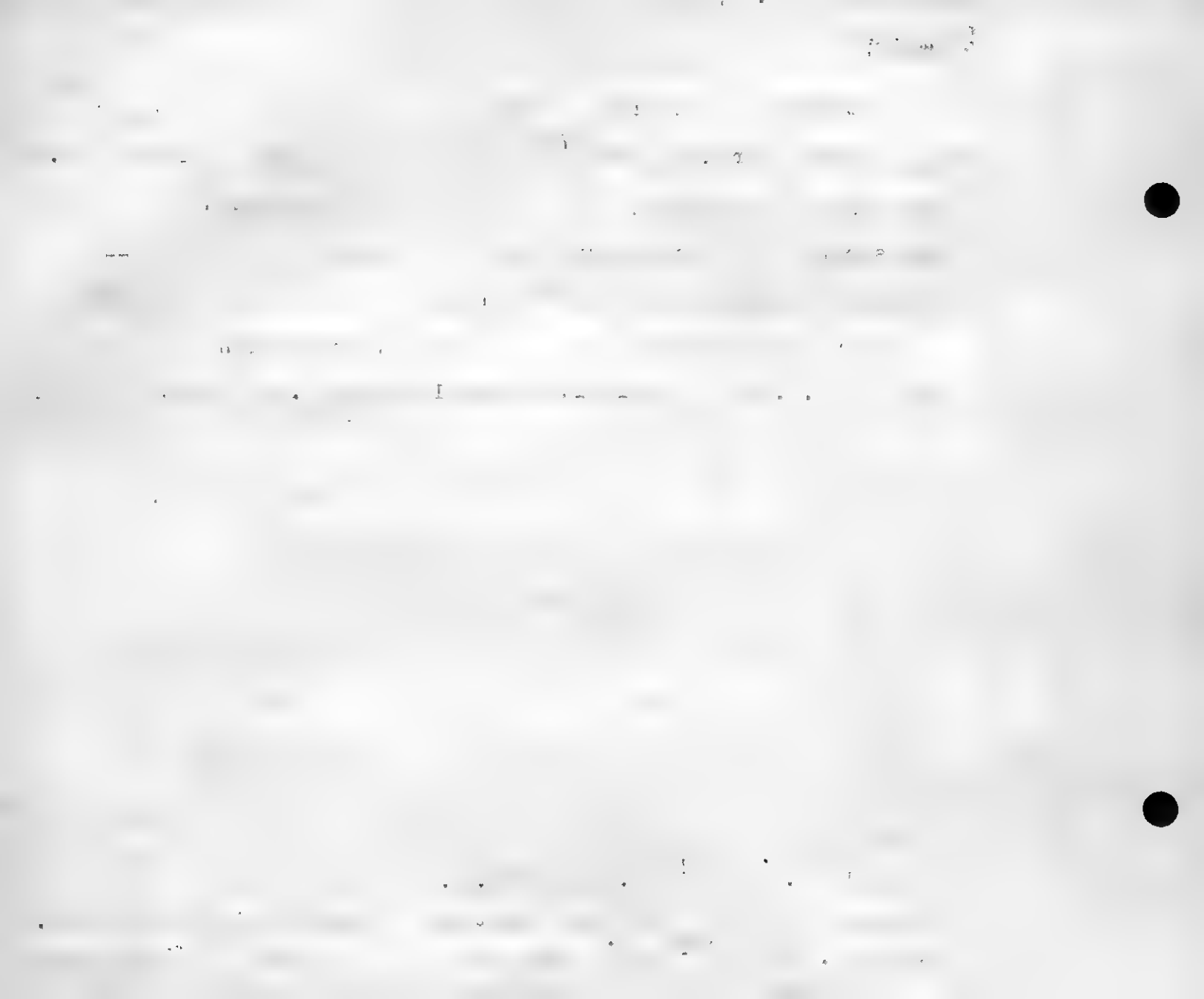


# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
CHARLES CLINTON MURRAY						Month Day Year Aug 11 1968		9 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	March 26 1893	75 YRS			Month Day Year Aug 14 1968		11.40 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		Washington				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Sharpsburg Pike			Farmer		--	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Washington			Hagerstown		Sharpsburg Pike	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Harry David Murray			Emma C. McLaughlin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Yes			N.W.#1			217-32-7011 Daniel Murray Clear Spring Md R #1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Twenty</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Posterior myocardial infarction</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Edward W. Ditto</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) <u>Edward W. Ditto, 111</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			<u>8-14-68</u>			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			8/15/68			Dunkard Cemetery			Broadfording Wash Co Md.
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hagerstown Md						DATE <u>AUG 16 1968</u>		<u>James J. Jones</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
10175 Item 5 Film 400 11/30/68  
**CERTIFICATE OF DEATH** 186

1. DECEASED NAME (Type or print) <b>CARRIE FAYE NICODEMUS</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR M
3. SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Dec. 30 1885</b>		6 AGE (In years lost birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Penna</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Washington</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash County Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>124 East Ave</b>	
14. FATHER'S NAME First Middle Last <b>Alfonso L. N icodemus</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Dora Morgal</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT Address <b>Ralph M. Nicodemus 36 East Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE <b>Francisco E. Rosillo</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) <b>FRANCISCO E. ROSILLO</b>				22e. ADDRESS <b>550 Northern Ave - Hagerstown</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B urial</b>	23b. DATE <b>8/26/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Waynesboro Franklin Co Pa</b>		
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>				25a. REC'D BY REGISTRAR <b>AUG 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

АХ ЗАДАЧА ПОСЛЕДОВАТЕЛЬНОСТИ

ИЗДАНИЕ ПЕРВОЕ

МОСКВА  
1950

ИЗДАТЕЛЬСТВО

МОСКОВСКИЙ УНИВЕРСИТЕТ  
ИЗДАТЕЛЬСТВО

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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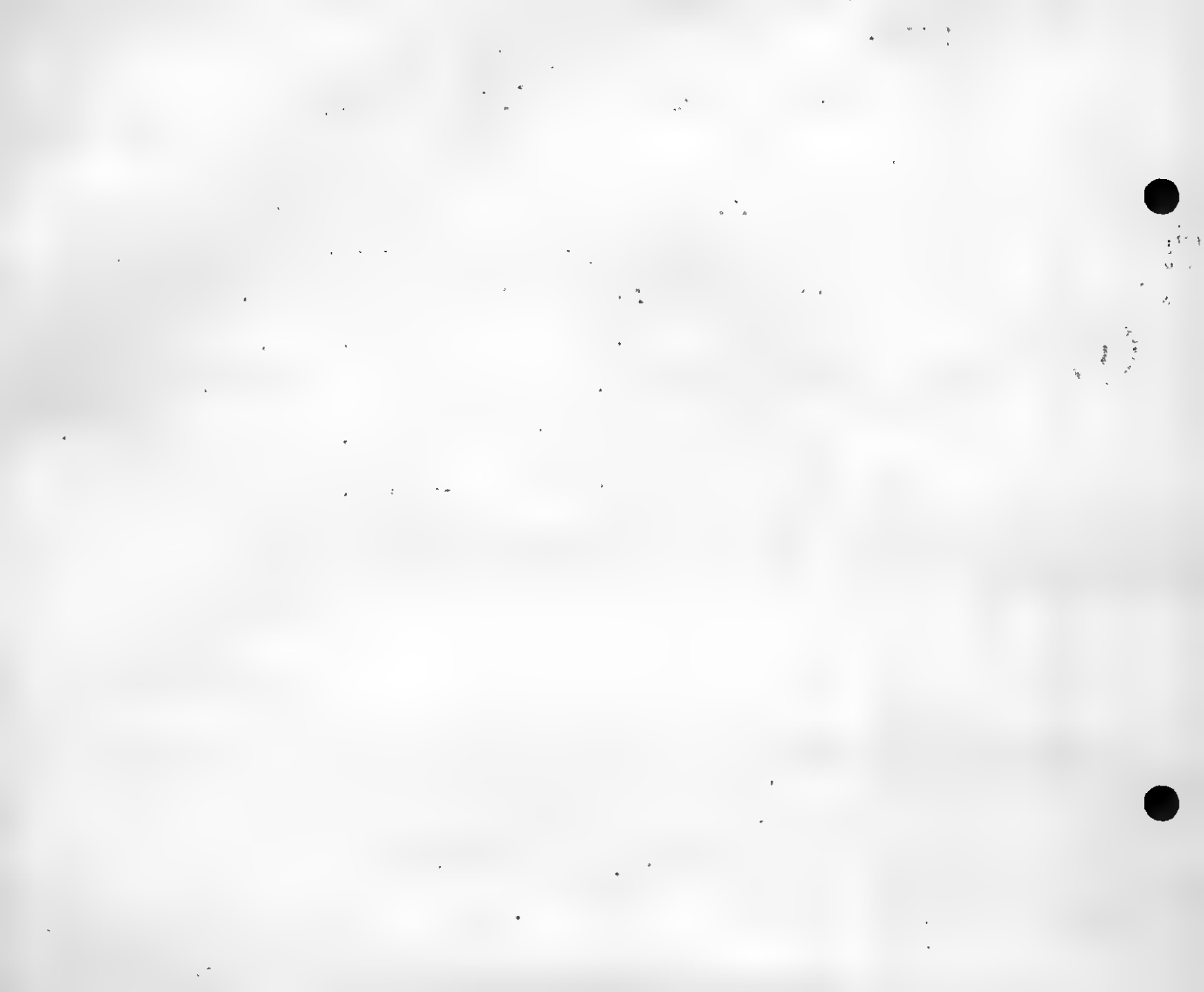
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) First Middle Last <i>Wilhelmina Julia NIKEL</i>						2a. DATE OF DEATH Month Day Year <i>Aug 22 1968</i>			2b. HOUR <i>11:35 AM</i>			
3 SEX <i>F</i>		4 RACE <i>W</i>		5. DATE OF BIRTH <i>Dec 11 1886</i>		6. AGE (in years lost birthday) <i>81</i> YRS			7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Richmond Va</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md						
10. CITY OR TOWN OF DEATH <i>Williamsport</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Homewood Church</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Va</i>				13b. COUNTY <i>None</i>		13c. CITY OR TOWN <i>Richmond</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>503 N. Lombardy St.</i>		
14. FATHER'S NAME First Middle Last <i>Frederick Otto Hillet</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Amalie Dietrich</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>230-70-4055</i>		17. INFORMANT <i>Mark Wagner</i>			Address <i>2750 14 Ave Wmpt, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) <i>Hypertensive C. Heart</i>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201 General Osteoarthritis</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1-4</i> , 1967, to <i>8-22</i> , 1968, that (I) (we) last saw the deceased alive on <i>8-22</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert P. Conrad</i>		DEGREE		ATTENDING PHYS		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>8-22-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Robert P. Conrad, M.D.</i>		22e. ADDRESS <i>374 Washington St</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8-24-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oakwood Cemetery</i>		23d. LOCATION (City or Town) <i>Richmond</i>		(County) <i>Virginia</i>		(State)		
24. FUNERAL DIRECTOR <i>Andrew K Coffman</i>				ADDRESS <i>FUNERAL HOME INC</i>		25a. REC'D BY REGISTRAR <i>Aug 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>				



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12173 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ETHEL SARAH RAFUS						AUGUST 18 68			2:40 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		AUGUST 25, 1906		67 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				WASHINGTON Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN			WASHINGTON COUNTY HOSPITAL			HOMEMAKER			OWN HOME
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			WASHINGTON		HAGERSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1440 HAMILTON BLVD.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
CLARENCE T FRAUL			CORA UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		
NO			219-28-4879		HENRY W RAFUS		1440 HAMILTON BLVD. HAGERSTOWN, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>									18 mo
1530 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Pecum</u>									18 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1530									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jun 2, 1968</u> to <u>AUG 18, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Aug - 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>Lloyd A. Hoffman</u> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN, M.D.					22e. ADDRESS		22f. REGISTRAR'S SIGNATURE		
					214 N. POTOMAC ST., HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		8/20/68		REST HAVEN CEMETERY		HAGERSTOWN WASHINGTON MD.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				HAGERSTOWN, MARYLAND		AUG 21 1968		<u>Charles Judge</u>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
OSCAR JOB RASH						Month Day Year AUGUST 11 1968		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		
MALE		WHITE		MAY 24, 1885		83 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNSYLVANIA		U.S.A.				WASHINGTON Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
HANCOCK			15 E. MAIN STREET			B&O RAILROAD TELEGRAPH OP.				
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			WASHINGTON		HANCOCK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15 E. MAIN STREET	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last WILLIAM G. RASH			First Middle Last ANGLINA MANN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
NO			705 05 8013		ELSIE H. RASH 15 E. MAIN ST. HANCOCK					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>									1 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>+109</u>										
(b) <u>ASHD + Passive Heart Failure</u>									5 years	
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7/63</u> , 19__, to <u>8/11/68</u> , 19__, that (I) (we) last saw the deceased alive on <u>6/2/68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		
<u>Frank B. Thomas III M.D.</u>								22c. DATE SIGNED 8/12/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
<u>Frank B. Thomas III M.D.</u>				<u>Hancock, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
BURIAL		8/13/68		PRESBYTERIAN CEMETERY		WARFORDSBURG FULTON PA				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>Howard J. Stone Hancock Md</u>						DATE AUG 15 1968		<u>Charles Judge</u>		

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MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12180											
1. DECEASED-NAME (Type or print)			First Homer			Middle Leon			Last Reed		
3 SEX Male			4 RACE White			5. DATE OF BIRTH March 4, 1926			2a. DATE OF DEATH Month August Day 6 Year 1968 10:21 P M		
7a. BIRTHPLACE (State or foreign country) S. Pool Isl.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.		
10 CITY OR TOWN OF DEATH Hagerstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Capt. of Police			12b KIND OF BUSINESS OR INDUSTRY Prison		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Washington			13c CITY OR TOWN Keedysville			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Jesse Middle Reed Last			15 MOTHER'S MAIDEN NAME First Margaret Middle Gladhill Last			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO. 220-13-3124		
17 INFORMANT Mrs. Catherine E. Reed			Address 18 Main St. Keedysville Md.			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>422</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>Aug 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Edson B. Moody</u>						22c DATE SIGNED <u>Aug 8, 1968</u>					
22d. PHYSICIAN'S NAME (Type) Edson B. Moody, M.D.						22e ADDRESS 363 S. Cleveland Ave. Hagerstown, Md. 21740					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 8-10-68			23c NAME OF CEMETERY OR CREMATORY Fairview Cemetery			23d LOCATION (City or Town) (County) (State) Keedysville, Wash. Co., Md.		
24 FUNERAL DIRECTOR John H. Barb, Jr. 112 N. Main St. Reonsboro, Md.						25a REC'D BY REGISTRAR AUG 12 1968			25b REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		

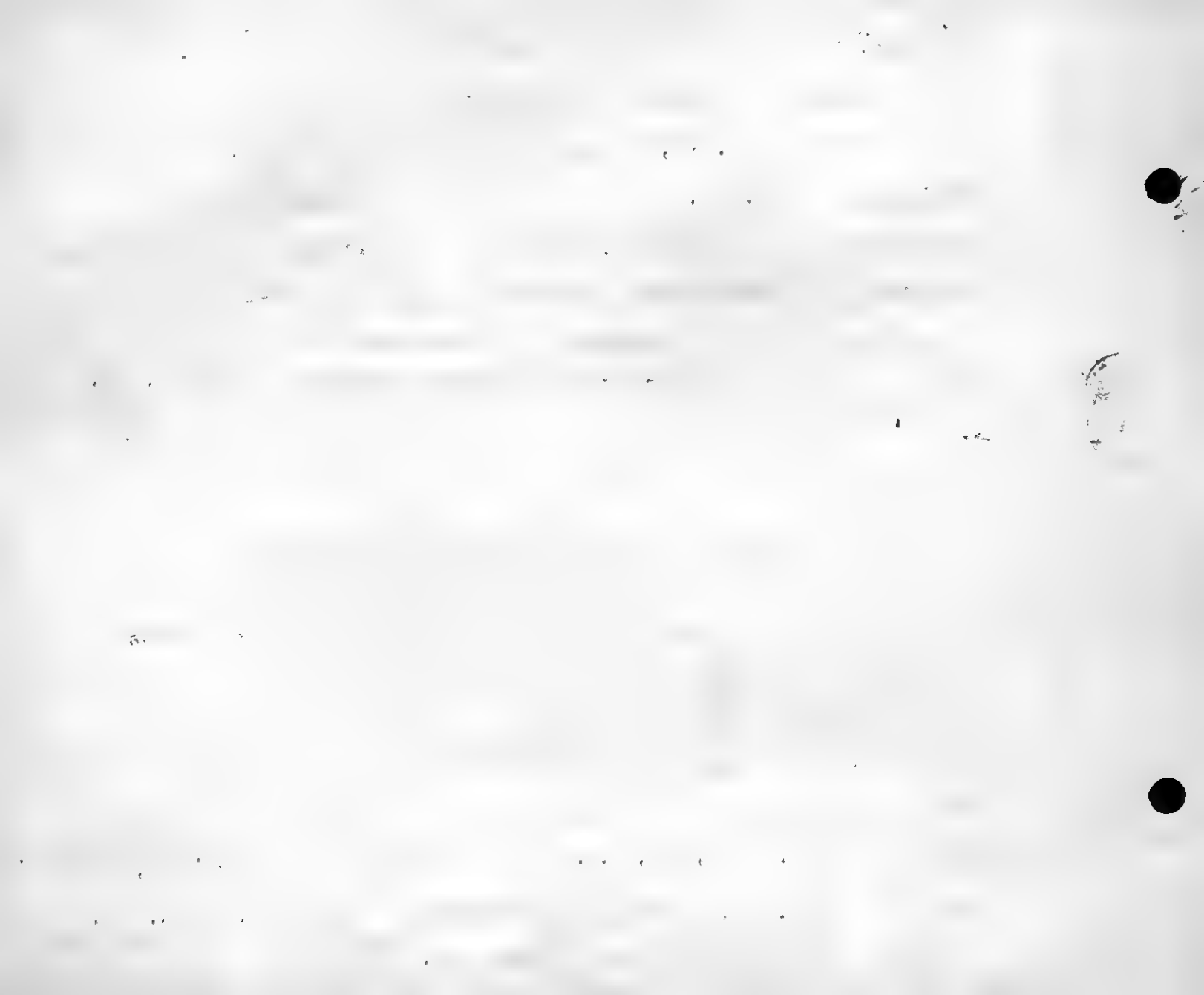


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										121812191			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH			2b HOUR	
Howard Marshall Ridenour									Month Day Year			5:30 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
Male		White		Sept. 14, 03		64 YRS		MONTHS DAYS		HOURS MIN		Month Day Year	
17a BIRTHPLACE (State or foreign country)		17b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH					
Maryland		U.S.A.		W DOWED		D VORCED		Washington					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown				Washington County				Trackman				Railroad	
13a USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY L.M. IS?		13e STREET AND NUMBER			
Maryland				Washington		Big Pool		YES NO		RED-1			
14 FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME			
Joseph Ridenour				First		Middle		Last		Sara Reed			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.		17 INFORMANT				ADDRESS			
No				705-10-5749		Rosalie Ridenour				Big Pool, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive cardiac vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Prostate Gland Enlargement, benign</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES NO					
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
CAUSE OF DEATH				HOUR A.M. P.M. 19									
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <u>8-12-68</u>					
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22c ADDRESS (Street, city, town, or county) <u>217 W. Washington St. Hagerstown, Maryland</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial				Aug. 14, 68		Park Head Cemetery			Park Head Wash. Md.				
24 FUNERAL DIRECTOR <u>Thompson Funeral Home</u>				25a REC'D BY REGISTRAR <u>Charles Judge</u>				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
Thompson Funeral Home Clear Spring, Md.				DATE AUG 15 1968									

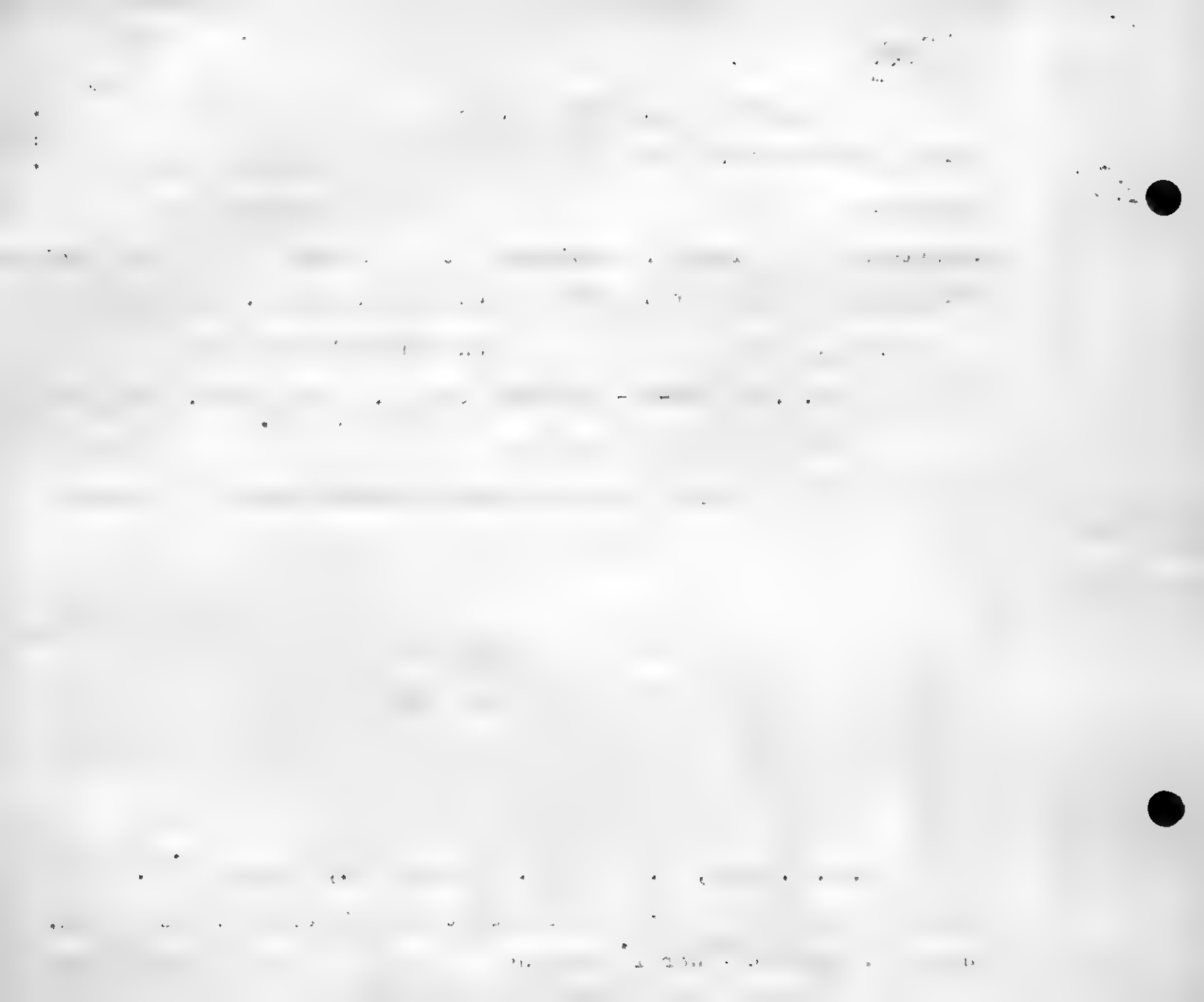


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <b>ELLIOTT LAWRENCE ROOF</b>						2a. DATE KNOWN OF DEATH Month <b>Aug</b> Day <b>23</b> Year <b>1968</b>		2b. HOUR <b>A. M.</b>		2c. DATE PRONOUNCED DEAD Month <b>Aug</b> Day <b>23</b> Year <b>1968</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>May 29 1899</b>	6 AGE (In years last birthday) <b>69 YRS</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>						
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1839 W. Washington St</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Plumber</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before) address on STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Hagerstown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>1839 W. Washington St</b>											
14. FATHER'S NAME First Middle Last <b>Frank R. Roof</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Anna Kate Eichelberger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16b. SOCIAL SECURITY NO (If yes give year or dates of service) <b>W.W.#1 214-09-1578</b>				17. INFORMANT ADDRESS <b>Mrs Olive T. Roof 1839 W. Washington St Hagerstown Md.</b>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>5 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dr. E. W. Ditte, Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>Aug. 24, 1968</b>			
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditte, Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>8/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md.</b>		
24. FUNERAL DIRECTOR <b>Hagerstown Md.</b>						25a. REC'D BY REGISTRAR <b>Andrew K. Coffman Funeral Home Inc</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



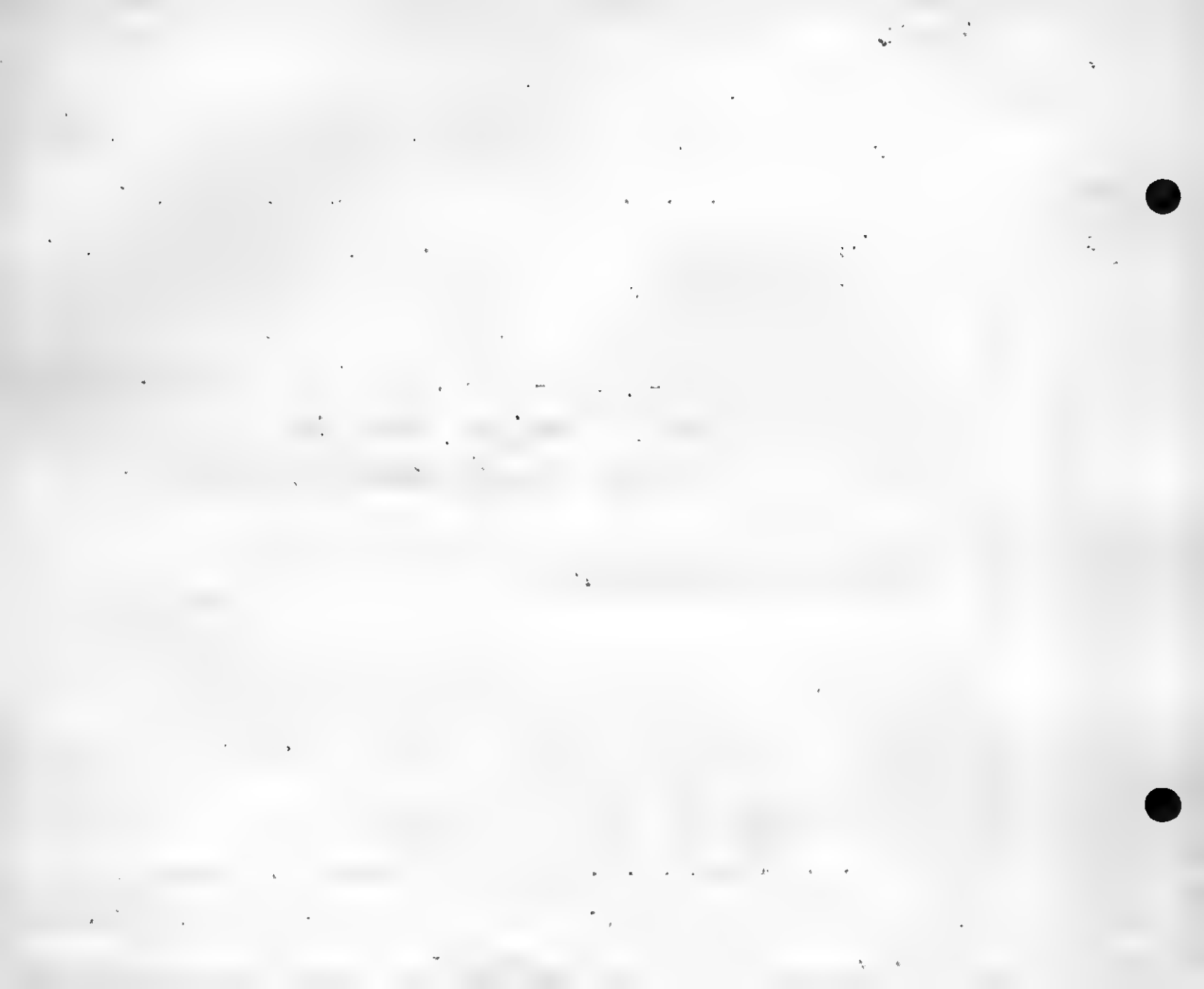
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
193											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <b>TONY</b> <sup>First</sup> <b>JOSEPH</b> <sup>Middle</sup> <b>SCALESE</b> <sup>Last</sup>						2a DATE OF DEATH <b>AUGUST</b> <sup>Month</sup> <b>22</b> <sup>Day</sup> <b>1968</b> <sup>Year</sup>			2b HOUR <b>9:10 PM</b>		
3. SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 1, 1898</b>		6 AGE (In years last birthday) <b>70</b> YRS.		7 UNDER 1 YEAR MONTHS		7 UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON COUNTY</b> Md					
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN, MD.</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHIN GTON CO. HOSP.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED GROCER</b>			12b KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>		13c CITY OR TOWN <b>SMITHSBURG</b>		13d INSIDE CITY, JIM TSP? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>Rt #3</b>		
14 FATHER'S NAME <b>JOSEPH</b> <sup>First</sup> <b>SCALESE</b> <sup>Middle</sup> <b>ROSE</b> <sup>Last</sup>				15. MOTHER'S MAIDEN NAME <b>MIRRELLO</b> <sup>First</sup> <sup>Middle</sup> <sup>Last</sup>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <b>175-18-8974-A</b>		17. INFORMANT <b>MRS. CATHERINE M. SCALESE SMHBG, MD.</b> Address <b>Rt #3</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary Heart Disease</b> (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>7-2-68</b> , 19 <b>68</b> , to <b>8-22</b> , 19 <b>68</b> , that (I) <del>(we)</del> saw the deceased alive on <b>8-15</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. R. Lardizabal, M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>8/23/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>E. R. Lardizabal, M. D.</b>						22e. ADDRESS <b>300 N. Potomac St. Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>AUG 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH CO., MD.</b>					
24. FUNERAL DIRECTOR <b>W.T. Norman</b> ADDRESS <b>RT. 5 Hagerstown</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

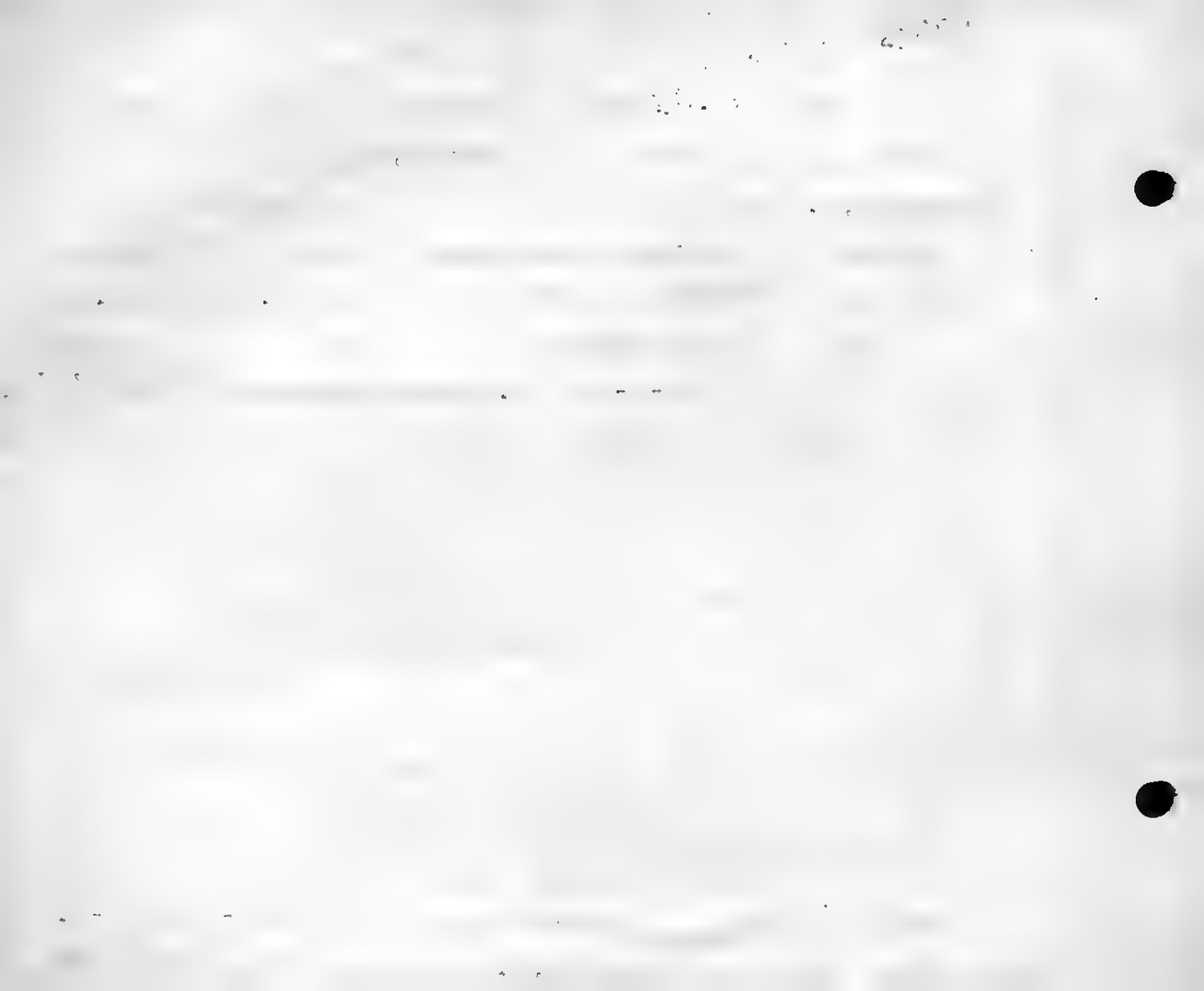
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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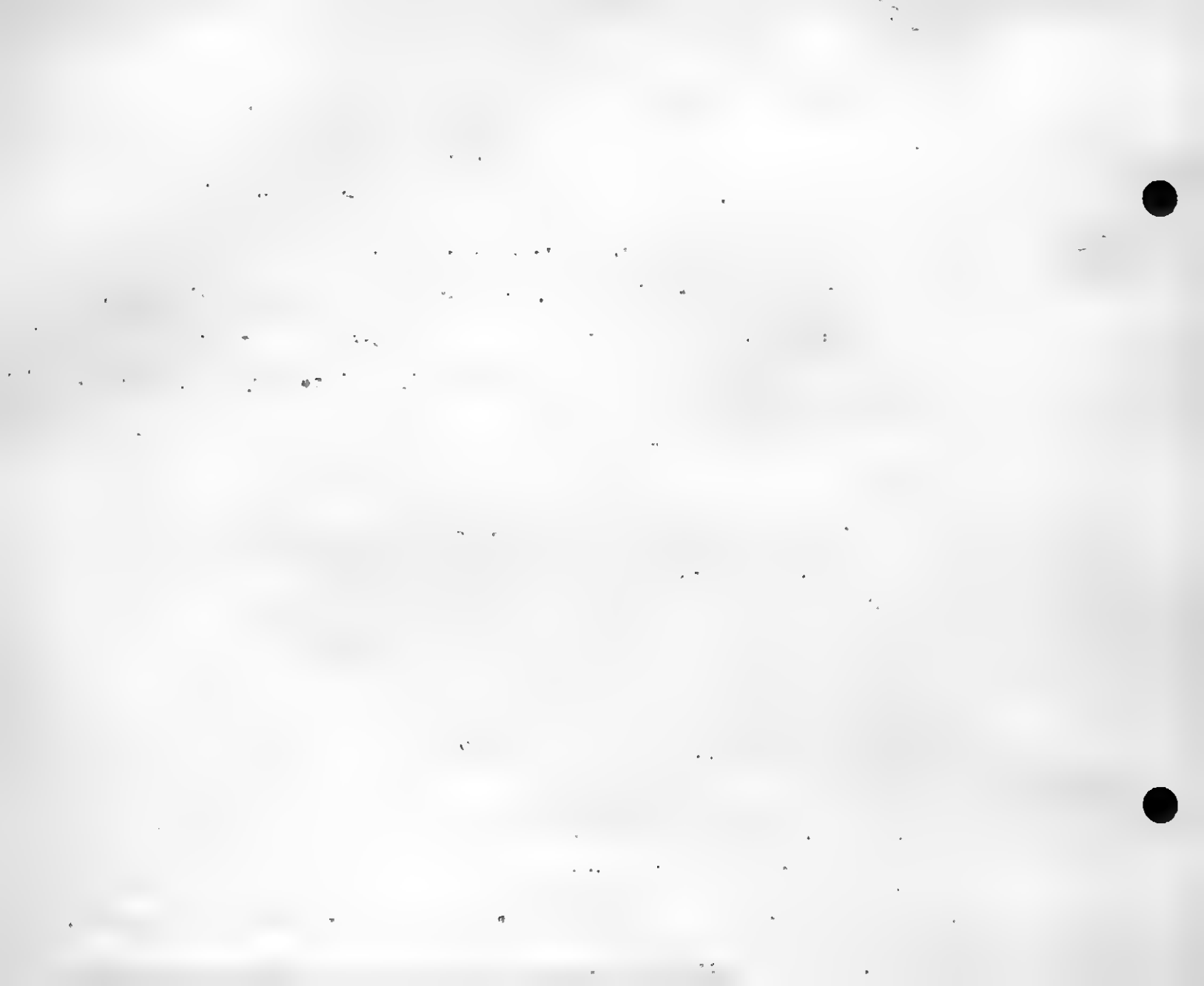
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
John William Shifflet						August 7 1968		8:30 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Male		White		August 14, 1898		69 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Singers Glen, Va.		USA				Washington		Hagerstown	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Washington County Hospital		Barber		Barber Shop					
13a. USUAL RESIDENCE (Where deceased lived, if not in an institution before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER			
Maryland		Washington		Hagerstown		641 W. Washington St.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
David Price Shifflet			Lavinia Shaeffer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		772-12-3032		Mrs. Catherine Blickenstaff		312 Devonshire Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4109</u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>10 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> , 19 <u>61</u> , to <u>8/7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
George Jennings		M.D.				8/9/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
George Jennings		318 N. Potomac St.		Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8/10/68		Rest Haven Cemetery		Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. C. Brown		Hagerstown, Md.		AUG 13 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12185 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>MARY</b> <b>ELIZABETH</b> <b>SHIPLEY</b>					2a. DATE OF DEATH Month <b>Aug.</b> Day <b>30</b> Year <b>1968</b>		2b. HOUR M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 25 1886</b>		6. AGE (In years last birthday) <b>81</b> YRS.		7. UNDER 1 YEAR MONTHS <b>11</b> DAYS <b>5</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington County</b>			
10. CITY OR TOWN OF DEATH <b>Williamsport</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>124 W. Salisbury St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>124 W Salisbury St.</b>	
14. FATHER'S NAME <b>Nathaniel</b> <b>Hunter</b> <b>Turner</b>			5. MOTHER'S M.A.DEN NAME <b>Sarah</b> <b>Elizabeth</b> <b>Ridenour</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>No</b>		17. INFORMANT <b>Mrs. Kenneth Schreyer</b>		Address <b>2702 Buford Dr. Williamsport Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion with Myocardial Infarction 5 minutes</b> <b>7100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery atherosclerosis</b> <b>unknown</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive arteriosclerotic heart Disease</b> <b>12 years</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>									
19a. DATE OF OPERATION <b>= = = =</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the doctor) attended the deceased from <b>04/09/56</b> , 19__, to <b>08/30/68</b> , 19__, that (I) (we) last saw the deceased alive on <b>08/09/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>Archie Robert Cohen</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 31, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.,</b>				22e. ADDRESS <b>Clear Spring, Maryland</b>					
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>		23b. DATE <b>Sept. 2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Williamsport Wash. Md.</b>			
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Young</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13185 CERTIFICATE OF DEATH 1136									
1. DECEASED-NAME (Type or print) First Middle Last <b>CLAUDE WILLIAM ANDREW SHIVES</b>					2a. DATE OF DEATH Month Day Year <b>AUGUST 18, 1968</b>		2b. HOUR P <b>5:30 PM</b>		
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 17, 1900</b>		6. AGE (In years last birthday) YRS. <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b>			
10. CITY OR TOWN OF DEATH <b>HANCOCK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>150 W. MAIN ST.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TAXI DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HANCOCK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>150 W. MAIN STREET</b>	
14. FATHER'S NAME First Middle Last <b>NOT KNOWN</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>KATE SHIVES</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-09-9355</b>		17. INFORMANT Address <b>ELSIE M. SHIVES 150 W. MAIN ST. HANCOCK, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarct</b> <b>1109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio sclerosis, long</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>taxi</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <b>8/16 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State <b>8/16 68 8/18 68</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/16 1968</b> to <b>8/18 1968</b> , that (I) (we) last saw the deceased alive on <b>8/16 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. Shaffer</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8/20/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>M. SHAFFER MD.</b>				22e. ADDRESS <b>HANCOCK, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>8/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REHOBETH METHODIST</b>		23d. LOCATION (City or Town) (County) (State) <b>HANCOCK FULTON PA.</b>			
24. FUNERAL DIRECTOR <b>Howard J. Stone Hancock md</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>			

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a summary of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a summary of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

16. The sixteenth part is a summary of the work done during the year.

17. The seventeenth part is a summary of the work done during the year.

18. The eighteenth part is a summary of the work done during the year.

19. The nineteenth part is a summary of the work done during the year.

20. The twentieth part is a summary of the work done during the year.

21. The twenty-first part is a summary of the work done during the year.

22. The twenty-second part is a summary of the work done during the year.

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1968 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Waneta Lucille Sigler						Aug. 12, 19			12:10 A.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR	
female	white	2-1-20	48 YRS					Aug. 12, 19		68 A.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.		USA		W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown			2 Park Ave.			clerk			dry cleaners		
13a USUAL RESIDENCE (Where deceased lived, admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			Wash.			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
Clarence Cramer			Leah Grumbine			2 Park Ave.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
no						Chester R. Sigler			Hagerstown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ruptured Congenital Aneurysm Of Left</u>										Instant	
DUE TO, OR AS A CONSEQUENCE OF <u>Vertebral Artery.</u>											
(b) <u></u>											
DUE TO, OR AS A CONSEQUENCE OF <u></u>											
(c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			HOUR A.M. P.M.								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED			22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
8-13-68			22d. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
22e. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22f. ADDRESS (Street, city, town, or county)								
Edward W. Ditto, JR., M.D.			25 U. S. Hagerstown, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
burial			8-14-68			Rest Haven Cemetery			Hagerstown, Md.		
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Minnich Funeral Home Hagerstown, Md.						DATE AUG 16 1968			Charles Judge		



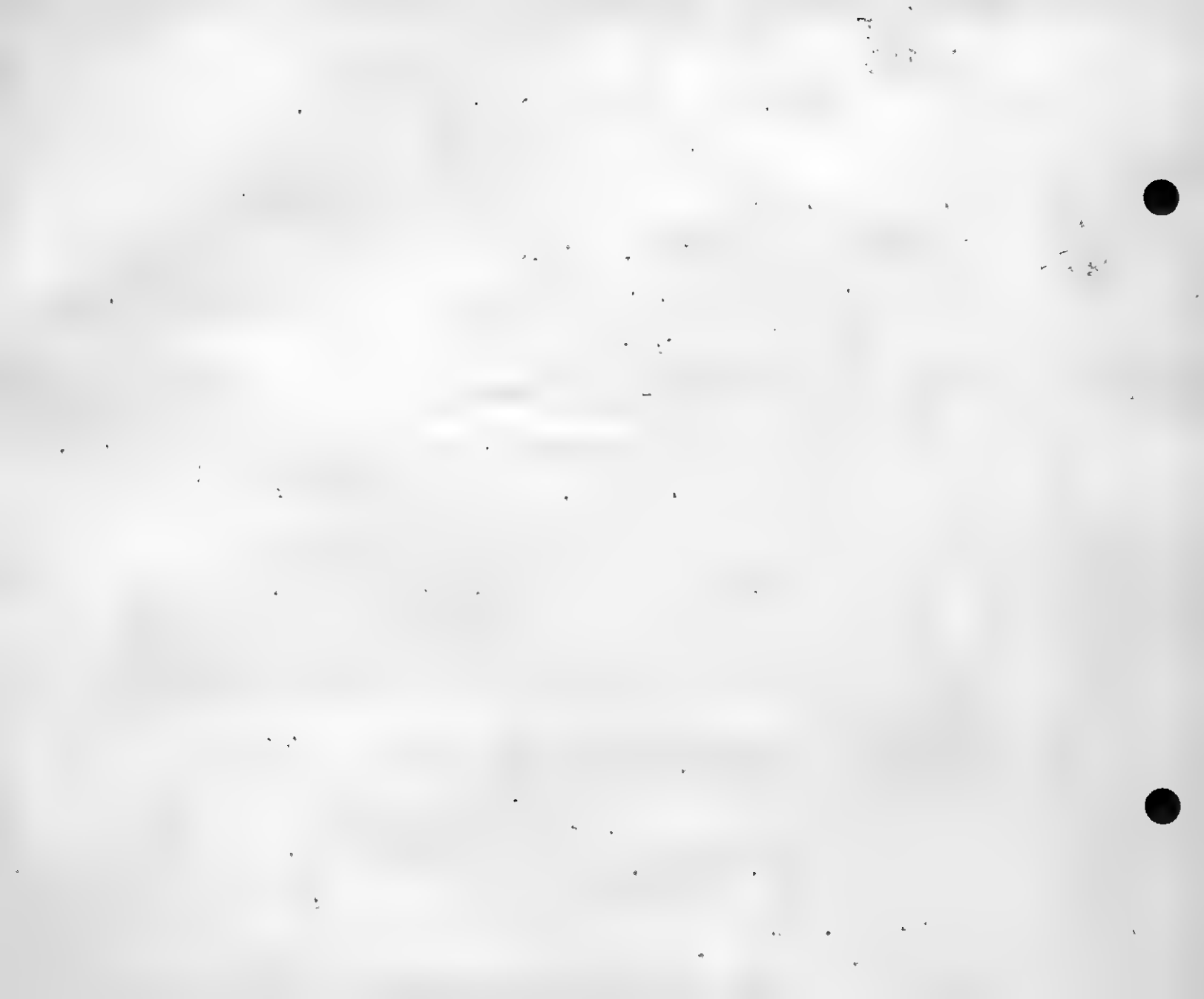
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12183

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First: Woodrow Middle: Wilson Last: Slonaker			2a. DATE OF DEATH Month: Aug. Day: 26 Year: 1968			2b. HOUR P: 9:40 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/3/13		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN:	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) carpenter		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland		13b. COUNTY: Prince George		13c. CITY OR TOWN: Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER: 2675 Walters Lane	
14. FATHER'S NAME First: James Middle: Slonaker Last: Slonaker			15. MOTHER'S MAIDEN NAME First: Florance Middle: Orndorff Last: Orndorff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 228-16-5498		17. INFORMANT Address: Records, Western Md State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus bilateral 4510 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 463x (b) Thrombophlebitis, left leg and right leg DUE TO, OR AS A CONSEQUENCE OF (c) unknown								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension arteriosclerotic cardiovascular heart disease & diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (we) attended the deceased from 4/16/68, 19, to 8/26, 1968, that (I) (we) last saw the deceased alive on Aug. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Chong Choon Han M.D.				22c. DATE SIGNED 8/26/68					
22d. PHYSICIAN'S NAME (Type) Chong C. Han, M.D.				22e. ADDRESS Western Md. State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE 8/29/68		23c. NAME OF CEMETERY OR CREMATORY Quaker Cemetery		23d. LOCATION (City or Town) (County) (State) Capon Bridge Hampshire W Va			
24. FUNERAL DIRECTOR Giffin Funeral Home				ADDRESS Capon Bridge W Va		25a. REC'D BY REGISTRAR DATE SEP 3 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12189  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Mary D. Smith</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR P <b>5:45 M</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>January 19, 1907</b>		6 AGE (In years lost birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md					
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INS DE CITY LIM. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>58 Meshack Frost Village</b>		
14. FATHER'S NAME First <b>William</b> Middle <b>Dohme</b> Last <b>Berry</b>			15. MOTHER'S MAIDEN NAME First <b>Ada</b> Middle <b>Berry</b> Last <b>Berry</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>219-14-7740</b>		17. INFORMANT Address <b>William S. Smith, Cleveland, Md. (SON)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion, acute</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <b>1 hour</b> <b>20 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Diabetes mellitus</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 20, 1968</b> , to <b>August 18, 1968</b> , that (I) (we) lost saw the deceased alive on <b>August 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Fe U. Porciuncula M.D.</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>8/19/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Fe U. Porciuncula, M.D.</b>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>8/20/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland Alle. MD.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>George Eichhorn Lonaconing, Md.</b>						25a. RECD BY REGISTRAR <b>DATE AUG 21 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

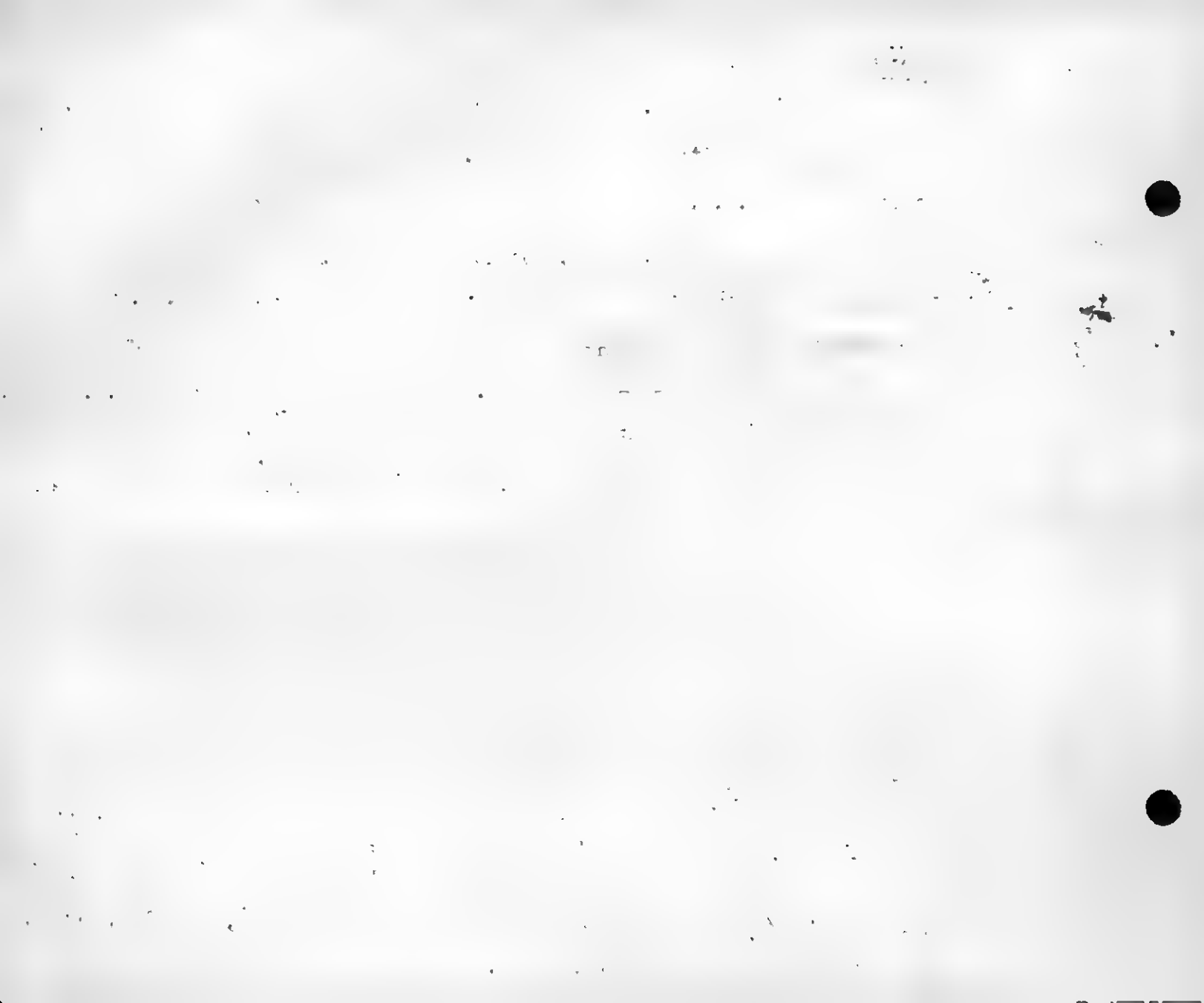
1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

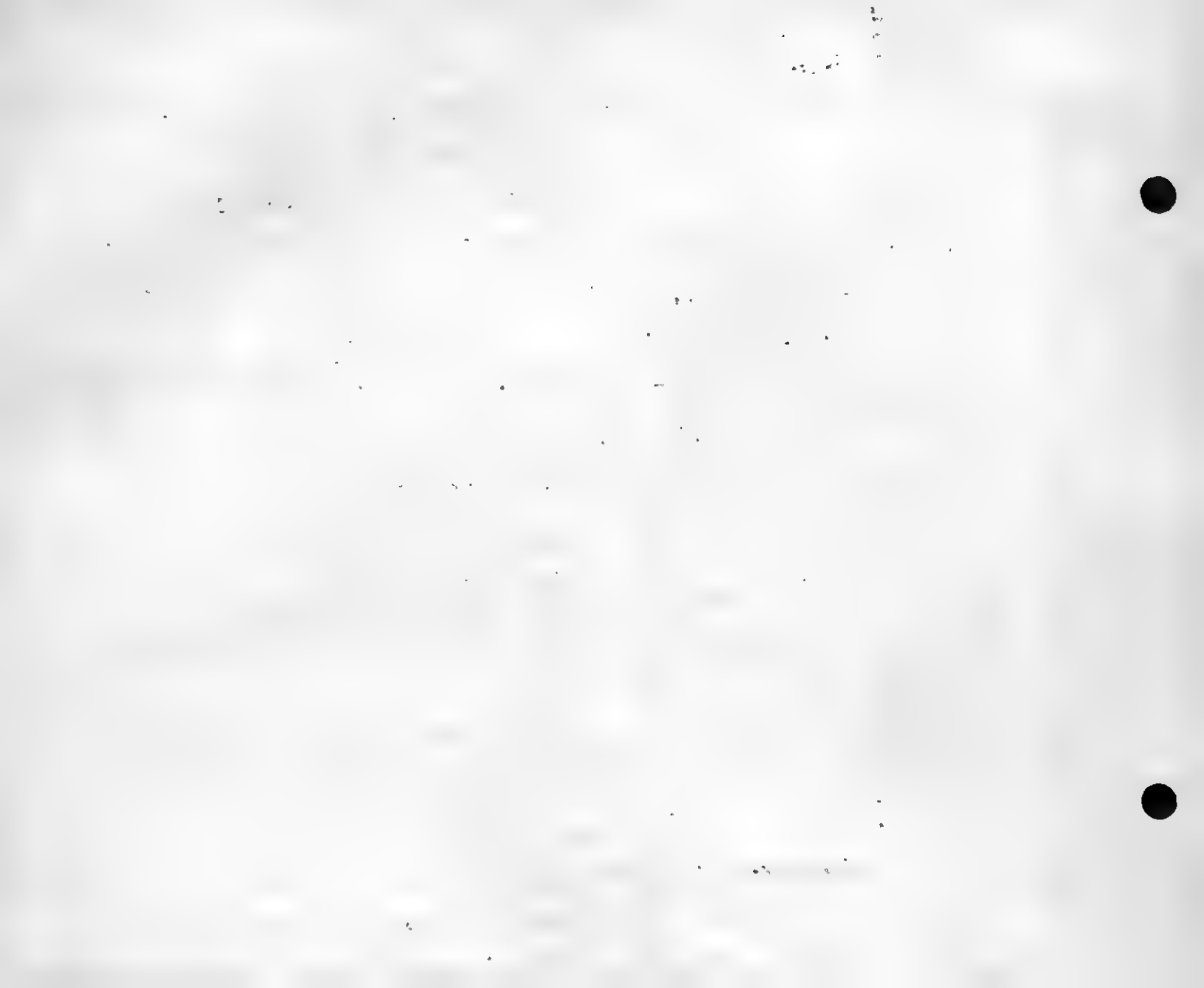
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
10190 CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Carrie			L. Snurr			Aug 19 1968		9:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Female		White		Dec. 9, 1885		82 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Washington Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co. Hospital			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Washington		Leitersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Hagerstown R. D. 5	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William			Shank			Mary Huffer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no			220-34-1149D		Mrs. Howard Hartle Hagerstown R.D. 5, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Large MI</u> <u>Heart Failure</u> <u>12/15</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> <u>Heart Dis</u> <u>on 12/15</u>										
(c) <u></u>										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
White <input type="checkbox"/> Not while at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>65</u> , to <u>8/19</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>8/19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>W. H. Anderson</u>		<u>MD</u>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<u>8-26-68</u>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
<u>W. H. Anderson</u>		<u>315 W. Preston St.</u>		<u>Hagerstown, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		8/22/1968		Green Hill		Waynesboro, Franklin, Penna.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>W. H. Anderson</u>		<u>Waynesboro, Penna.</u>		DATE <u>AUG 23 1968</u>		<u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

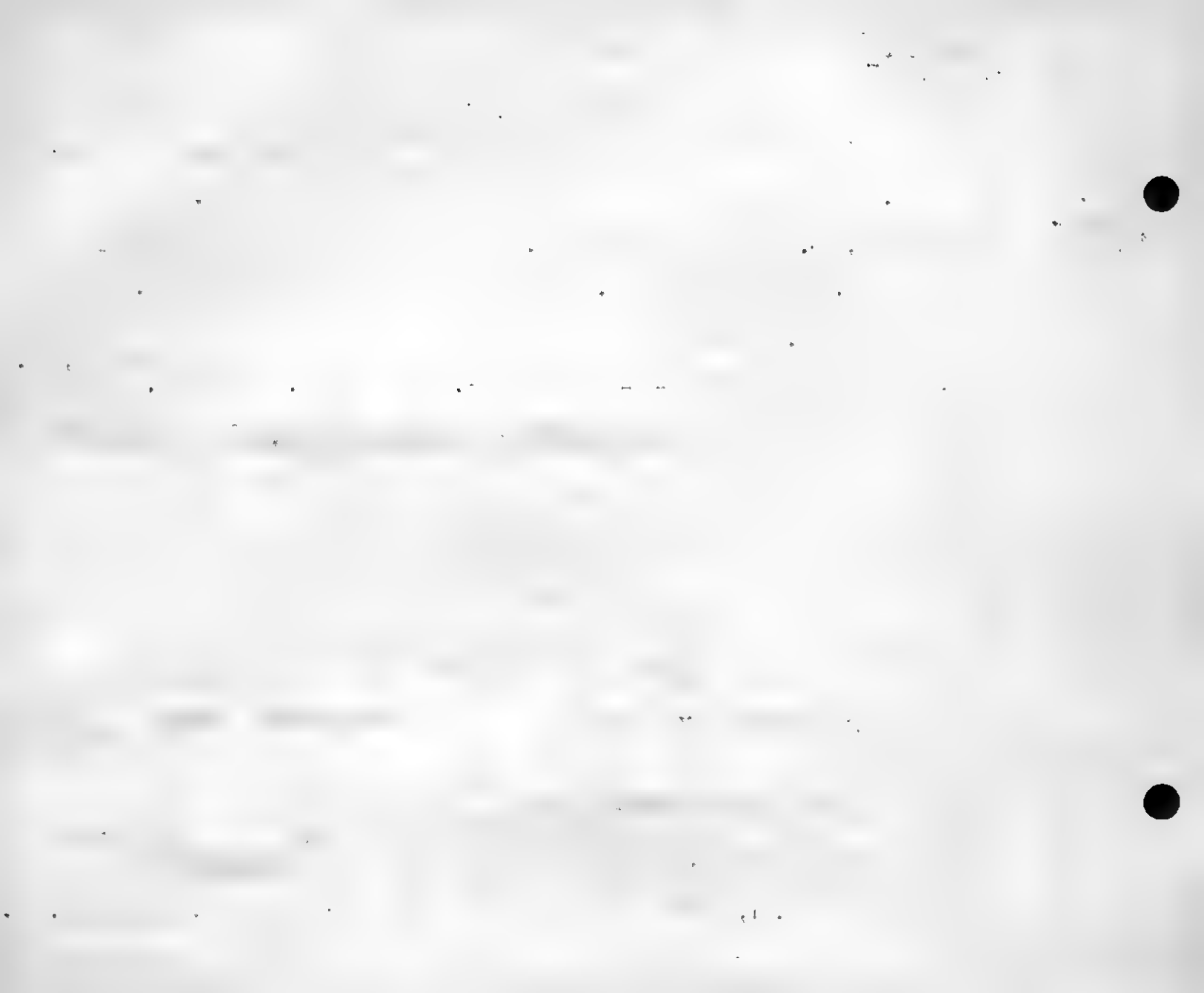
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12191 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Ezra Earl Spielman						August 19, 1968			1:45 P.M.
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. IF UNDER 1 YEAR	
male		white		12-6-1890		77 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State, or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown			Wash. County Hospital			General work			Dairy
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md.			Wash.		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		101 Roessner, Ave.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles E. Spielman			Emma Danner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			220-28-8231		Mr. Donald R. Spielman Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1621</u>									
(b) <u>Primary Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Arteriosclerosis Heart Failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>William O. Rehrig M.D.</u>								8/21/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
William O. Rehrig M.D.				145 J. Prospekt St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8-22-1968		Rest Haven Cemetery		Hagerstown, Wash. Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md.				DATE AUG 23 1968		<u>Charles Judge</u>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

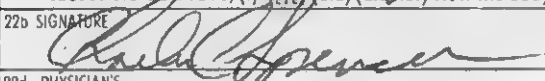

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
L MARGUERITE			STAIK			Month Day Year		P. M.	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	11/6/1920	47 YRS	MONTHS	DAYS	Month Day Year		P. M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH			
Pa.		USA		NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington Co.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown, Md.			554 Frederick St.			School Teacher		Public School	
13a. USJA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Md.			Washington Co.			Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
First Middle Last			First Middle Last			554 Frederick St.			
Seba B. Staik			Leila Leiby						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS			
no			205-09-9569			Chambersburg, Pa.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			self inflicted gun shot wound of chest						
DUE TO, OR AS A CONSEQUENCE OF			sudden						
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
976x									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
<input checked="" type="checkbox"/>			HOUR A.M. P.M.		SUICIDE				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State				
			554 Fred St. (Apt)		Hagerstown Wash MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL EXAMINER'S NAME (Type)			580 NORTHERN AVE. M.D.			22b DATE SIGNED			
HOWARD N WEEKS, M.D. HAGERSTOWN, MD.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			8/29/68			
			ADDRESS (Street, city, town, or county)			580 Northern Ave.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Aug. 31, 1968		LINCOLN CEMETERY		Chambersburg, Franklin Co. Pa.			
24 FUNERAL DIRECTOR ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
HAGERSTOWN, MARYLAND			DATE SEP 6 1968			Charles Judge			

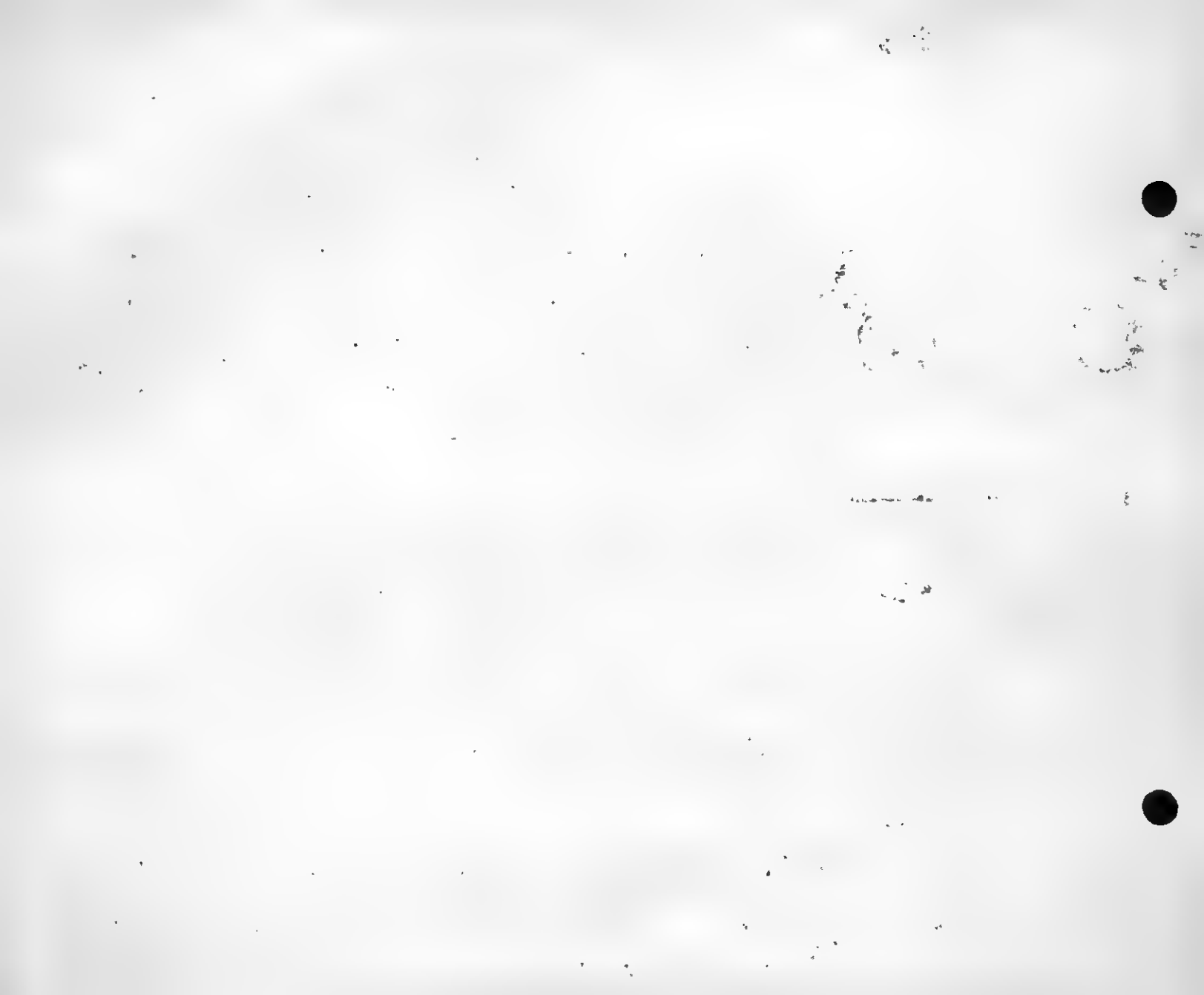


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12193  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>WILLIAM</b>			First Middle Last			2a DATE OF DEATH Month <b>11</b> Day <b>68</b> Year			2b. HOUR M			
3. SEX <b>MALE</b>			4 RACE <b>WHITE</b>			5 DATE OF BIRTH <b>JANUARY 1, 1893</b>			6 AGE (In years last birthday) <b>75</b> YRS.			
7a. BIRTHPLACE (State or foreign country) <b>GREECE</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>WASHINGTON</b> Md.			
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>AVALLON MANOR NURSING HOME</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>OWNER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HAGERSTOWN</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME <b>GERGE</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>EFIDIA</b>			First Middle Last <b>GIORANAKE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-09-2488A</b>			17. INFORMANT <b>MRS. YVONNE STAVROS</b>			715 Address: <b>GUILFORD AVE. HAGERSTOWN, MARYLAND</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Duodenal ulcer with recent Bleeding.</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or RFD No. City or Town County State						
22a. I certify that (I) <del>(the physician)</del> attended the deceased from <b>June 8, 1968</b> to <b>Aug</b> , 1968, that (I) <del>(we)</del> last saw the deceased alive on <b>Aug 4</b> , 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did)</b> view the body after death.												
22b. SIGNATURE 						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>8/12/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>CHARLES C SPENCER, M.D.</b>						22e. ADDRESS <b>145 S. PROSPECT, HAGERSTOWN, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>8/13/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>WILLIAMSPORT WASHINGTON MD.</b>			
24. FUNERAL DIRECTOR 						ADDRESS <b>HAGERSTOWN, MARYLAND</b>			25a. RECD BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>REBECCA EILEEN</b>			First Middle Last <b>Strawburg</b>			2a. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>68</b>			2b. HOUR <b>5:30 P M</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>8-28-1868</b>			6. AGE (In years last birthday) <b>99</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington</b> Md.		
10. CITY OR TOWN OF DEATH <b>Beonsboro</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Fairway-Keedy Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE KEEPER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>CARROLL UNION BRIDGE</b>			13c. CITY OR TOWN <b>Union Bridge</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME <b>Joseph</b>			15. MOTHER'S MAIDEN NAME <b>Susan</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>214-54-0368</b>		
17. INFORMANT <b>JAMES WARREN FELTZ</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Anterior MI</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>			Address <b>MD</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 16, 1968</b> to <b>Aug 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 19, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. W. LeVan M.D.</b>			22c. DATE SIGNED <b>Aug. 19, 1968</b>			22d. PHYSICIAN'S NAME (Type) <b>G. W. LeVan M.D.</b>			22e. ADDRESS <b>Boonsboro Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>AUG 22, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>			23d. LOCATION (City or Town) (County) (State) <b>NEW WINDSOR RURAL MD</b>		
24. FUNERAL DIRECTOR <b>W. Hartzler &amp; Sons</b>			25a. REC'D BY REGISTRAR <b>AUG 22 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>					



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VR A15 (4)  
30M REV. 1-68

12195

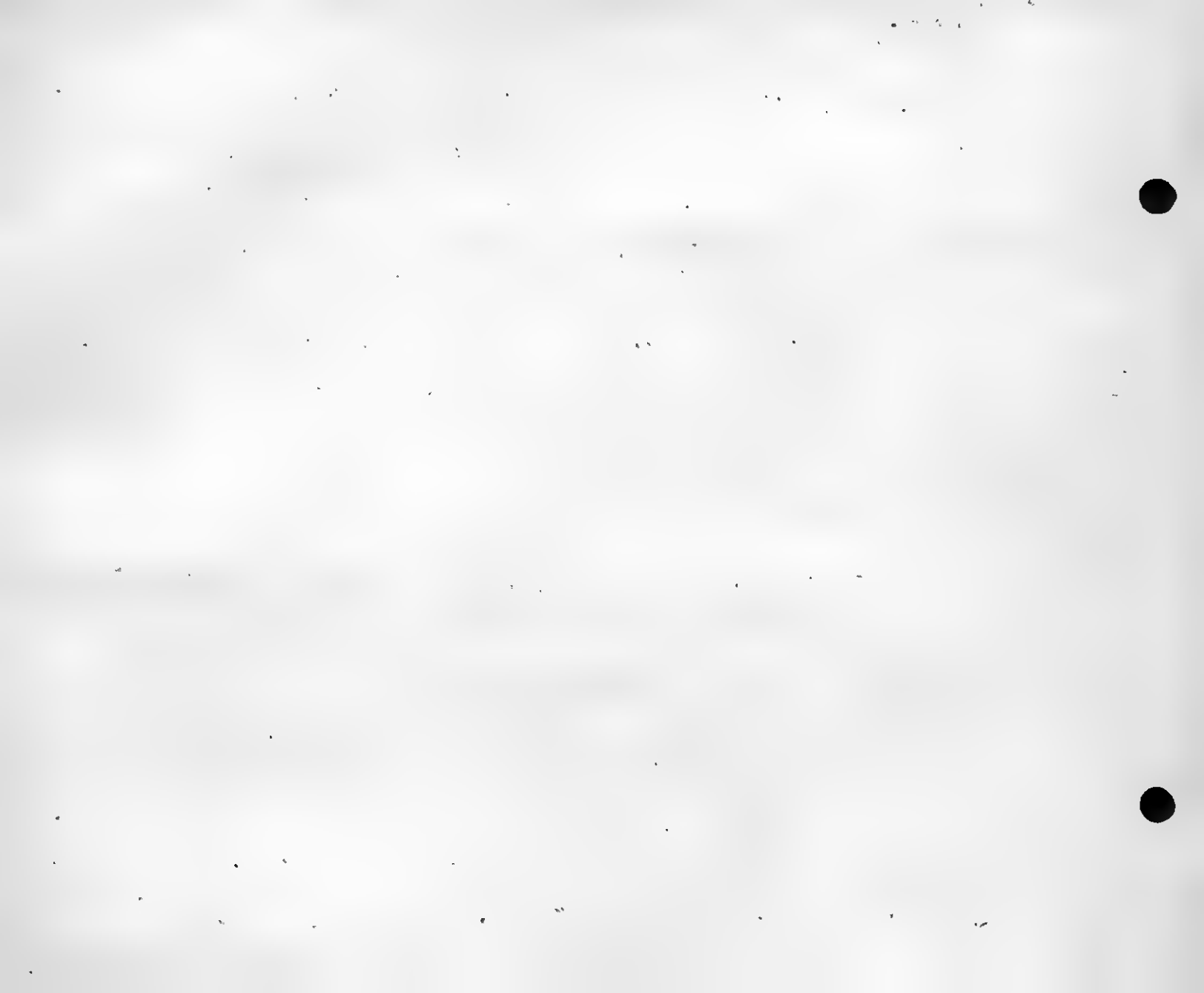
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12205

1. DECEASED NAME (Type or print) <b>CLARA</b>		First Middle Last <b>SULLIVAN</b>		2a. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>1968</b>		2b. HOUR <b>9:58</b> AM	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>MAY 7, 1894</b>		6. AGE (In years last birthday) <b>74</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b>	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>LITTLETON</b>		15. MOTHER'S MAIDEN NAME <b>CLARA ALBERS</b>		13e. STREET AND NUMBER <b>715 Main St.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Wm. Sullivan Laurel Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>3110</b> DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4010</b>							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Rheumatoid Arthritis, Hydropericarditis, Severe Coronary Atherosclerosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 28, 1967</b> , to <b>Aug 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>August 10, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>F. U. PORCIUNELA M.D.</b>				22c. DATE SIGNED <b>Aug 11, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>F. U. PORCIUNELA</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>8-13-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Laurel Md</b>	
24. FUNERAL DIRECTOR <b>Wm. J. H.</b>				25a. REC'D BY REGISTRAR <b>Laurel Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. H.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last Margaret Louise Sweeney					8 Month 8 Day 68 Year				
3. SEX female		4. RACE white		5. DATE OF BIRTH 5-28-1887		6. AGE (In years last birthday)		7b. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wash.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 435 Liberty St.		12a. USUAL OCCUPATION (Kind of work done during week before death, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 435 Liberty St.	
14. FATHER'S NAME First Middle Last Jacob Semler					15. MOTHER'S MAIDEN NAME First Middle Last Anna Mead				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Robert Sweeney Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>+ generalized arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4200</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 28, 1966</u> , to <u>Aug 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edward W. Ditto</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8-9-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto</u>				22e. ADDRESS <u>217 W. Washington St. Hagerstown, Md.</u>					
23a. B. RIAL, CREMAT ON, RENEWAL (Specify)		23b. DATE 8-12-68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR Minnick Funeral Home Hagerstown, Md.				25a. RECD BY REGISTRAR DATE <u>AUG 12 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



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MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12197 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR M	
CHARLES RUSSELL TRAIL						AUGUST 21, 1968			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		MARCH 24, 1904		64 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
MARYLAND		U.S.A.				WASHINGTON		HAGERSTOWN	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
WASHINGTON COUNTY HOSPITAL		FARMER		ORCHARDS					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		WASHINGTON		HANCOCK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD #1	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
WILLIAM N TRAIL			HELEN M NORRIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
NO			212-14-7093		AMANDA R. TRAIL RFD #1 HANCOCK, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>								2 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary + Cerebral Atherosclerosis</u>								1 yr.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>4201</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Thrombotic Occlusion Rt. Middle Cerebral Artery</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 16</u> , 1968, to <u>Aug 21</u> , 1968, that (I) ( <u>we</u> ) last saw the deceased alive on <u>Aug 20</u> , 1968, and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.									
22b. SIGNATURE <u>Carol A. Hoffman</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8/23/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>214 N. Pot. St. Hagerstown Md.</u>				22e. ADDRESS <u>214 N. Pot. St. Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		8/24/68		PINEY PLAINS METHODIST ALLEGANY CO., MARYLAND		LITTLE ORLEANS			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Richard J. Jones</u>		<u>Hancock, Md.</u>		DATE <u>AUG 27, 1968</u>		<u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First <b>DANIEL</b> Middle <b>F.</b> Last <b>TROUT</b>			2a. DATE OF DEATH Month <b>Aug.</b> Day <b>13</b> Year <b>1968</b>		2b. HOUR <b>8:30</b> AM
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>Jan. 30, 1915</b>		6. AGE (In years last birthday) <b>53</b> YRS	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>McConnellsburg, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Wash. Co. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Mason</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Const.</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b> CITY OR TOWN <b>Bethesda</b>		13b. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13c. STREET AND NUMBER <b>6211 Poe Rd.</b>		14 FATHER'S NAME First <b>Daniel</b> Middle <b>F.</b> Last <b>Trout, Sr.</b>		15. MOTHER'S MAIDEN NAME First <b>May</b> Middle <b>Johnston</b> Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>579-07-8000</b>		17 INFORMANT <b>Mrs. Daniel F. Trout Bethesda, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute Protein myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>many years</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 10, 19 68</b> to <b>Aug 13, 19 68</b> , that (I) (we) last saw the deceased alive on <b>Aug 13, 19 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Edson B. Moody</b>		22c. DATE SIGNED <b>Aug. 14, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Edson B. Moody</b>	
22e. ADDRESS <b>Hagerstown, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/16/68</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Union</b>		23d. LOCATION (City or Town) (County) (State) <b>McConnellsburg, Pa.</b>		23e. ADDRESS <b>Mercersburg, Pa.</b>	
24. FUNERAL DIRECTOR <b>Th. L. Lingers</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

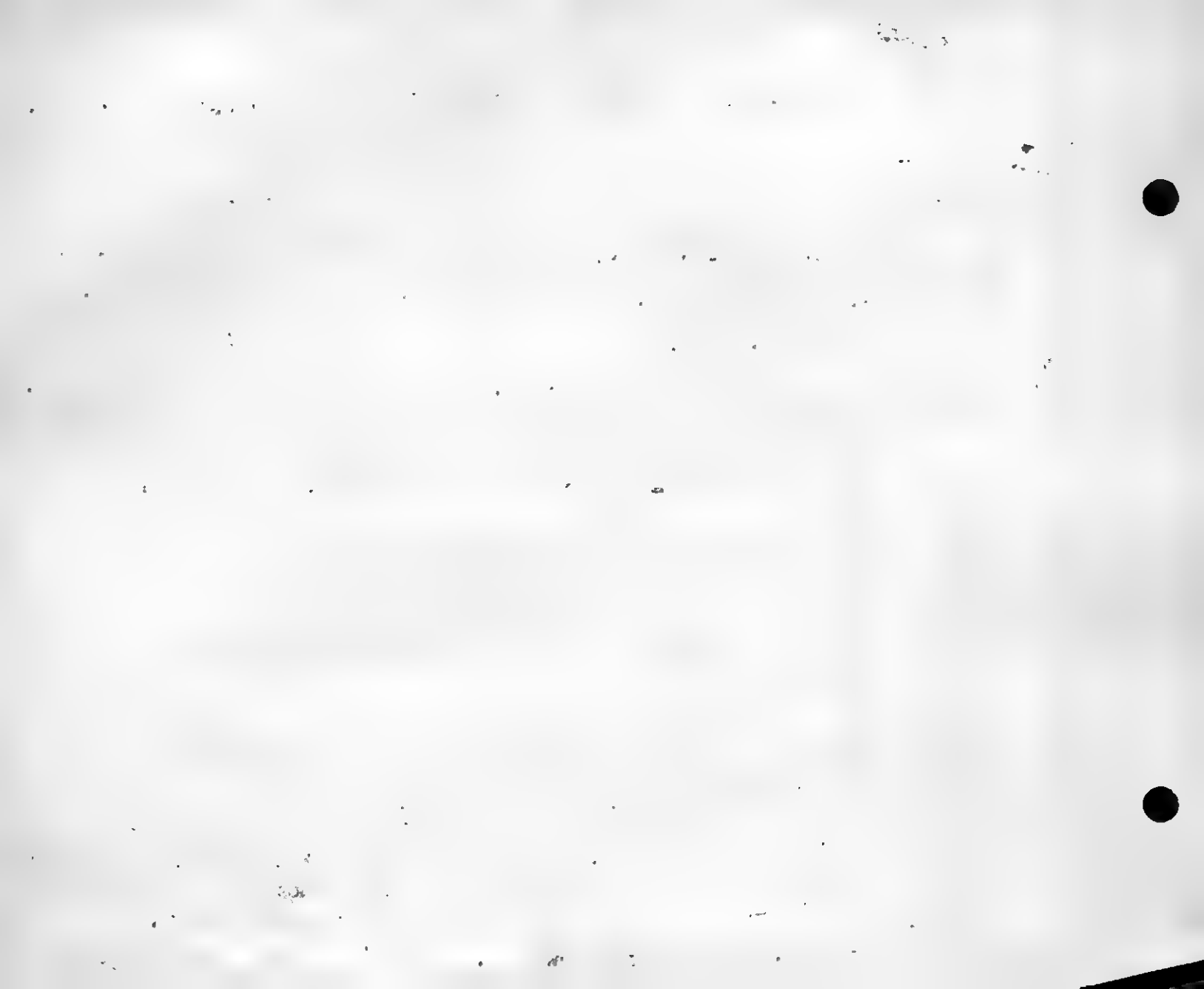
105

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Catharine Pearl Trovinger</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1968</b>			2b. HOUR <b>6:20 A.M.</b>	
3 SEX <b>female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH <b>4-7-1904</b>		6 AGE (In years last birthday) <b>64</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. County Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
13a. USUAL RESIDENCE (Where deceased lived, if at institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>11 W. Magnolia, Ave.</b>							
14. FATHER'S NAME First Middle Last <b>William R. Itneyer</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Laura V. Neff</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-09-6503</b>		17. INFORMANT Address <b>Mr. Donald Trovinger, Dobbs Ferry, N.Y.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>iliac artery.</b> <b>+407</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Years</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>450</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>19/5/68</b> , 19____, to <b>8/6/68</b> , 19____, that (I) (we) last saw the deceased alive on <b>8/4</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Howard N. Weeks</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/6/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22e. ADDRESS <b>580 Northern Ave., Hagerstown Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-8-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

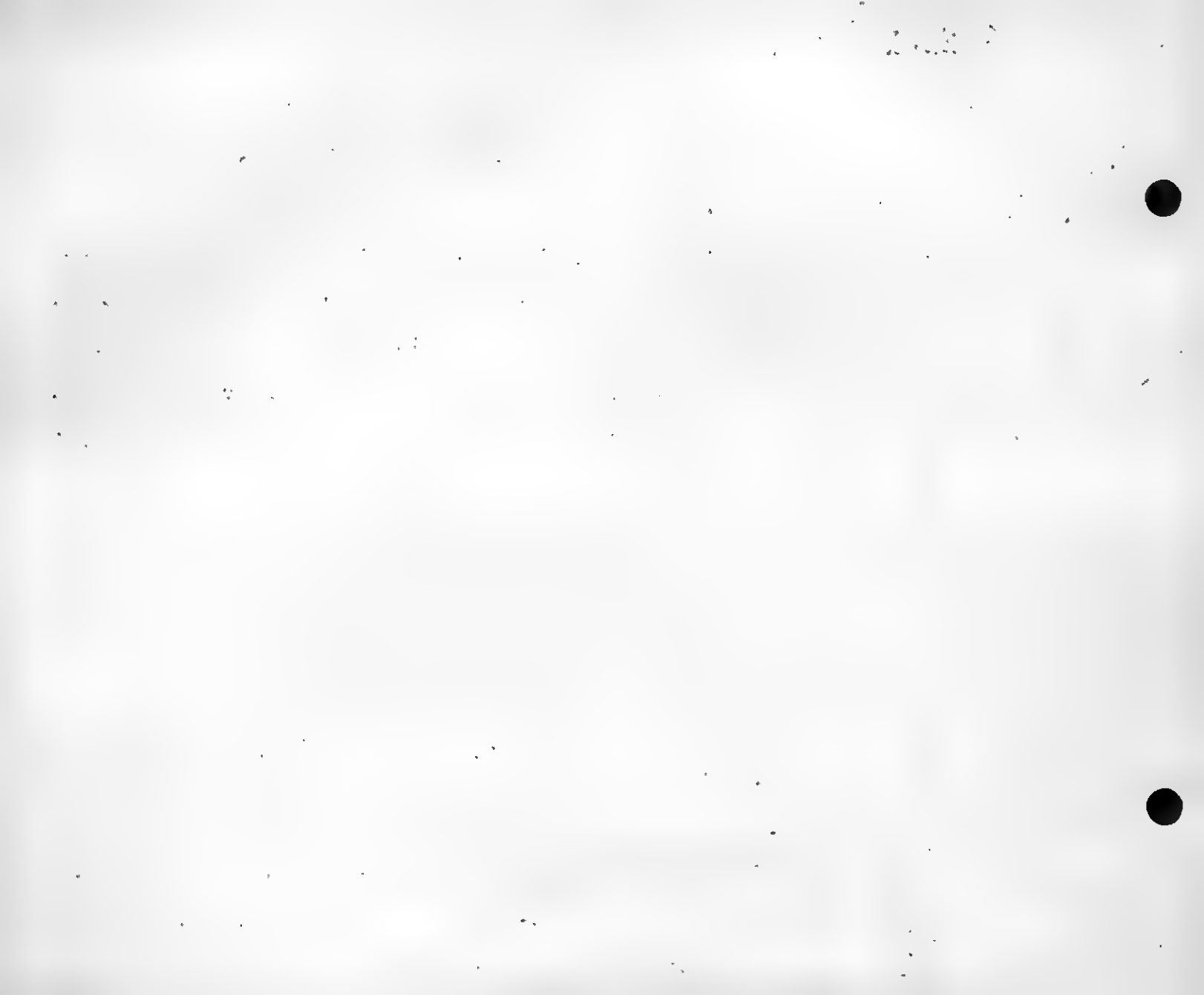
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12200

# CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last NORA CAROLINE TULLIS			2a. DATE OF DEATH Month Day Year AUGUST 30 68			2b. HOUR a m 5:50			
SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JANUARY 16, 1882		6. AGE (In years last birthday) 86 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY, IN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 450 E NORTH PROSPECT ST.	
14. FATHER'S NAME First Middle Last HARRY S BLOOM			15. MOTHER'S MAIDEN NAME First Middle Last NANNIE E MYERS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-44-6495		17. INFORMANT Address N.M. TULLIS, 302 CENTRAL AVE., GLYNDON MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hr. 15 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from Aug. 29, 1968, to Aug. 30, 1968, that (I) (we) last saw the deceased alive on Aug. 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B.B. KNEISLEY, M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8/30/68			
22d. PHYSICIAN'S NAME (Type) B.B. KNEISLEY, M.D.		22e. ADDRESS 148 W WASHINGTON ST., HAGERSTOWN, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/1/68		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASHINGTON MD.			
24. FUNERAL DIRECTOR Charles E. Rieger				ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Grace Matilda Watts						MATED <input type="checkbox"/> <input checked="" type="checkbox"/> Aug 19 1968			11:25 A.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	Colored	9-20-1834	83 YRS			Month Day Year			12:10 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Clear Spring		USA				Washington			MD
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown Md.			617 Pennsylvania Ave.			Evangelist			
13a. U.S.A. RESIDENCE (Where deceased lived, if not in institution)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland			Washington			Hagerstown			617 Pennsylvania Ave
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Josiah Watts			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
No			165-07-2343			Miss Anna Watts 617 Pennsylvania Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Pulmonary Hemorrhage</u>									Instant
DUE TO, OR AS A CONSEQUENCE OF (b) <u>(Possibly Ruptured Aortic Aneurysm)</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
<i>E. W. Ditte, Jr.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Aug. 20, 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
Dr. E. W. Ditte, Jr.			215 W. Washington St., Hagerstown, Md.						
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			8-23-1968			Rose Hill Cemetery			Hagerstown Wash Md.
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. RECEIVED BY SUCCESSION JUDGE
John R. Watson Jr. Hagerstown Md.						AUG 22 1968			

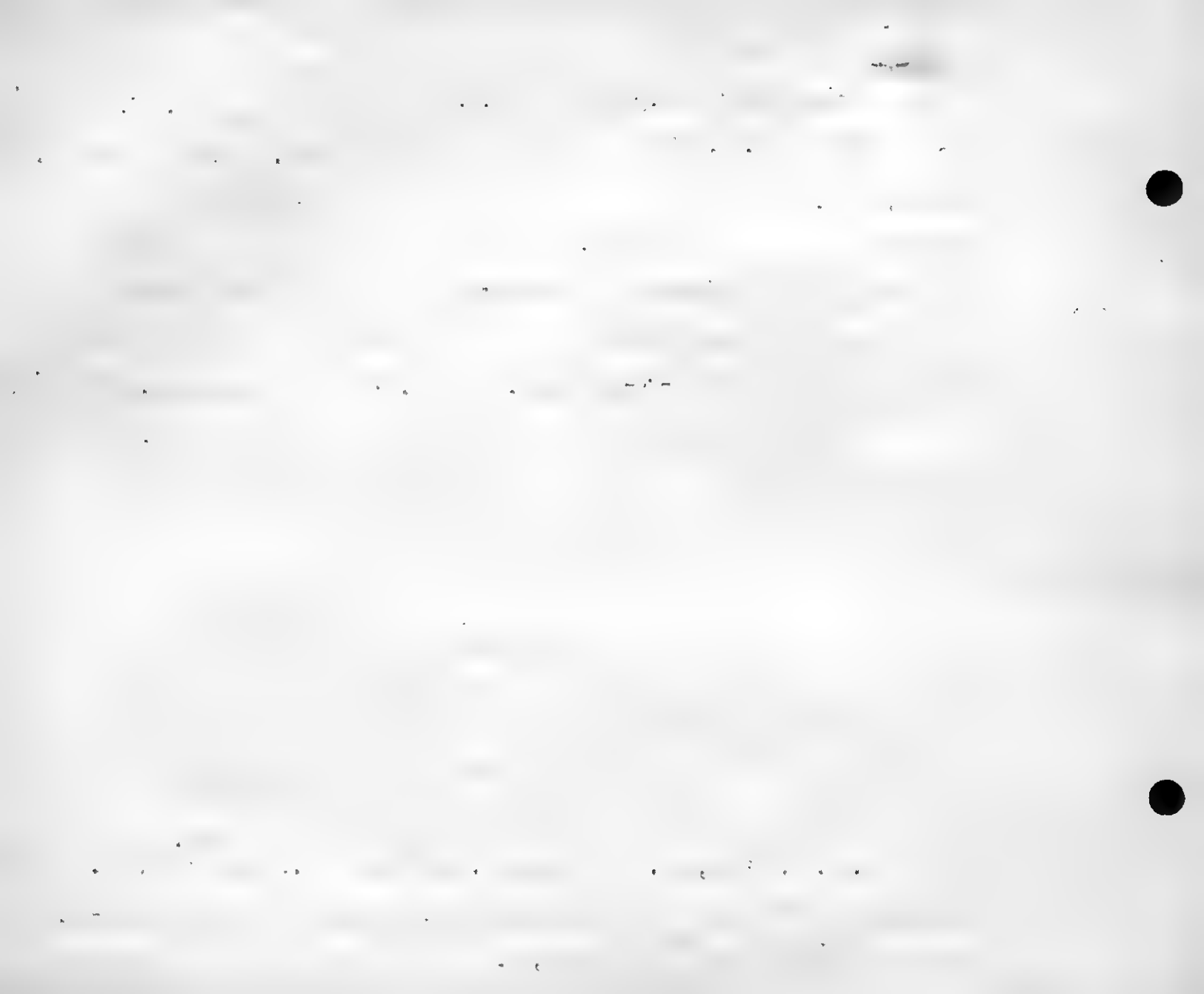


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 21-22a Film 401 9-3-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10-14-68 ams 12202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1 DECEASED NAME (Type or Print)						First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR					
John Franklin Bernard						WOLF						DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> Aug. 22, 1968		6 P. M.					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR					
Male		White		Feb. 12, 1918		50 YRS		MONTHS DAYS		HOURS MIN		Month Day Year Aug. 22, 1968		8:50 P. M.					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED		9 COUNTY OF DEATH									
Richland, Penna.				USA				WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY			
Hagerstown				Washington Co. Hospital DOA								Salesman				Insurance-Auto			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE						13b COUNTY		13c CITY OR TOWN		13d INS DE CITY, TOWNSHIP		13e. STREET AND NUMBER							
Maryland						Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1017 Columbia Road							
14 FATHER'S NAME						First		Middle		Last		15. MOTHER'S MAIDEN NAME							
Harry						Edwin		WOLF				Helen Lucile Yiesley							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO		17 INFORMANT								ADDRESS			
Yes						UW 11		214-09-8141		Mrs. Glenne E. Wolf								1017 Columbia Rd. Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> 9109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Instant							
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
MEDICAL CERTIFICATION																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
						6 HOUR AM PM Aug 22 1968				Drowning									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town		County		State			
								Big Poole, Rural Wash.				Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																			
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED							
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						Aug. 24, 1968							
Dr. E. W. Ditte, Jr.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
23a BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial						8/26/68		Rest Haven Cemetery				Hagerstown-Washington-Md.							
24 FUNERAL DIRECTOR						ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Wm. A. Horst						Rest Haven Funeral Chapel Hagerstown, Md.				DATE AUG 29 1968				Charles Judge					

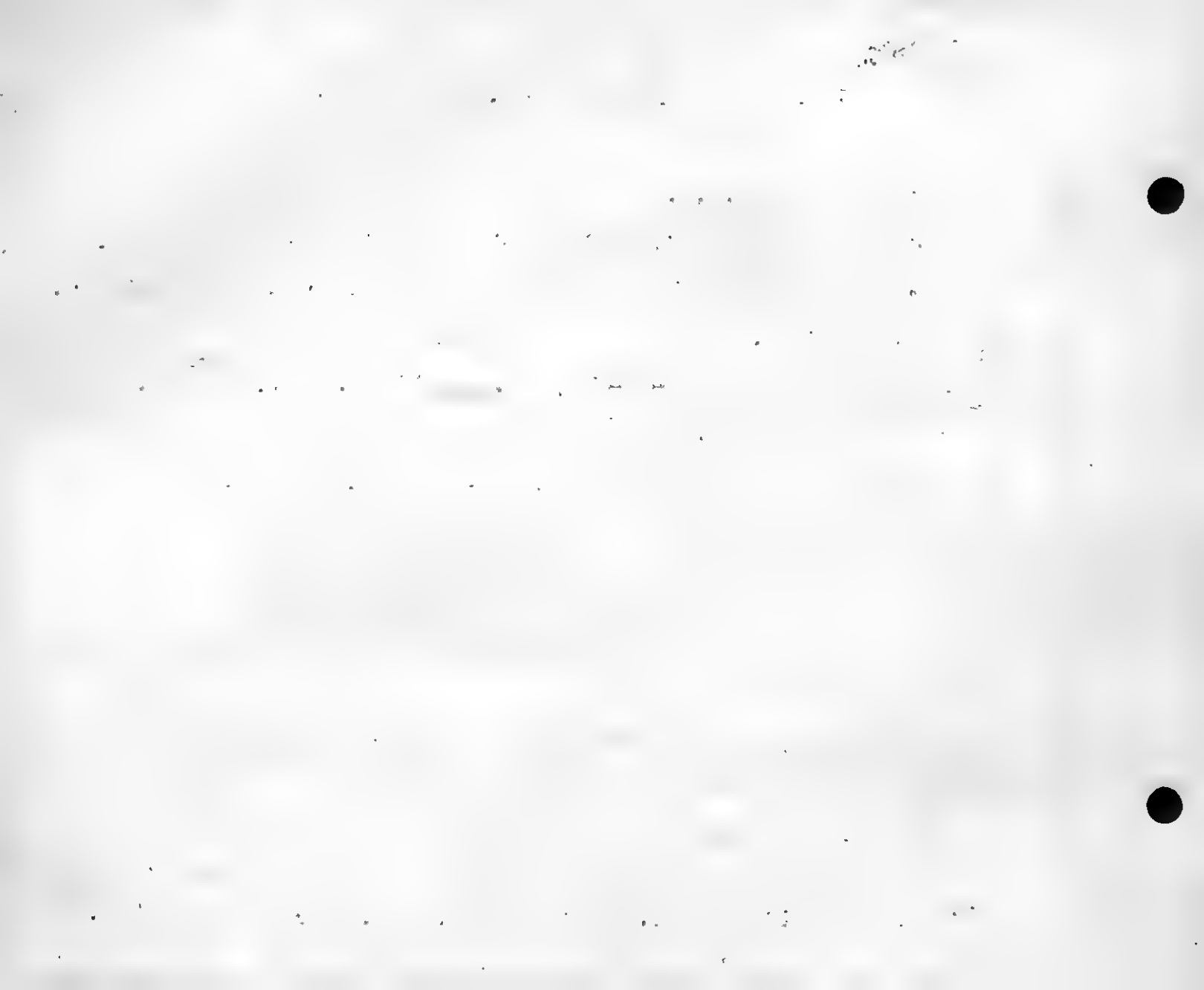


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

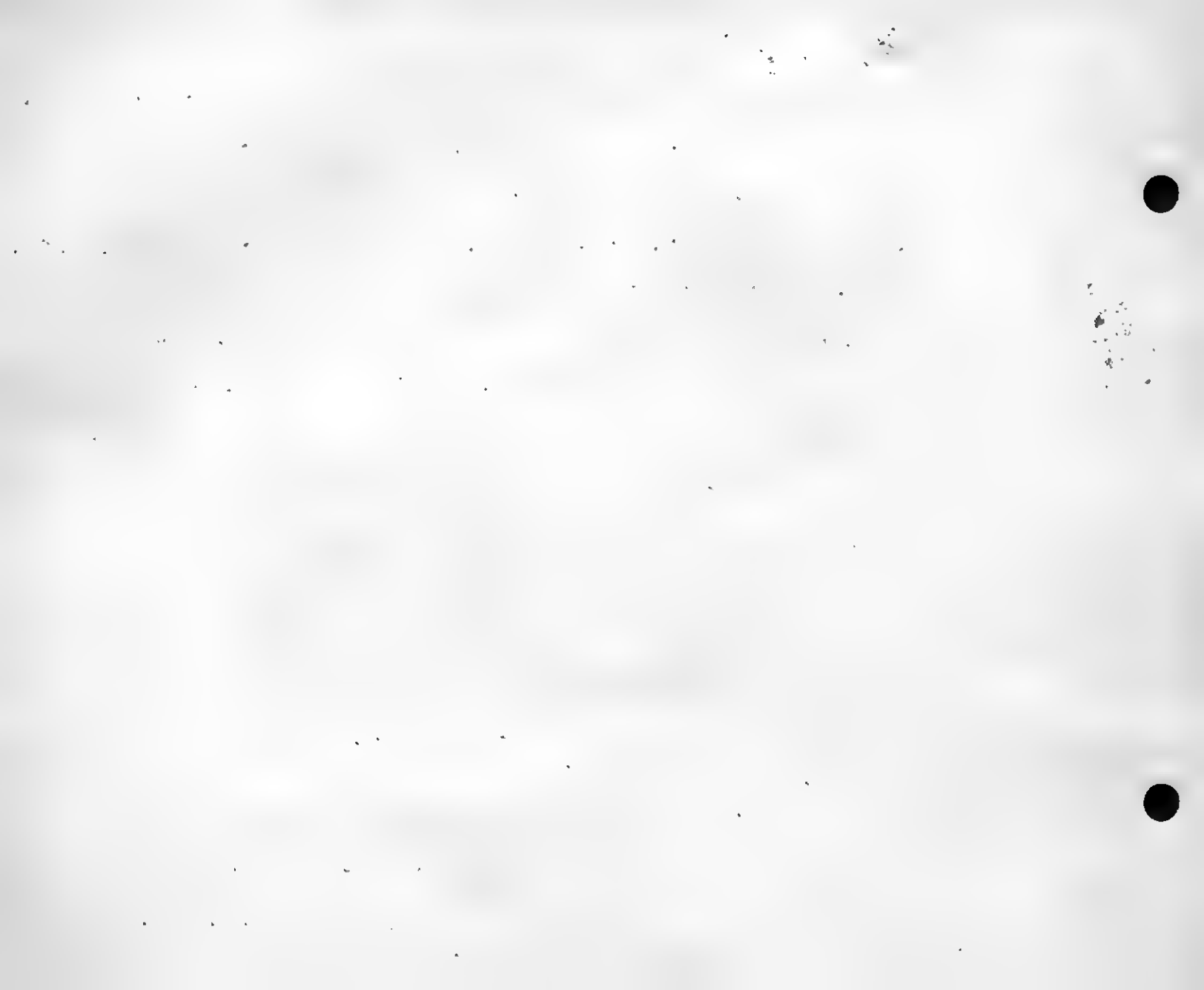
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15208 Item 5 Film 6408 37174									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First		Middle		Last	Month		Day	Year	Hour
CLAUDE		CHESTER		WOLFE	AUGUST		18	Day	1968
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS	
MALE		WHITE		10/26/68 1894		75 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				WASHINGTON Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last 12 months)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		AVALONMANOR HOME		RETIRED MESSENGER		BANK			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER	
MARYLAND		WASHINGTON		HAGERSTOWN				28 W. LONGMEADOW RD.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					
WILLIAM H.		LIZZIE GARBER		HAGERSTOWN MD.					
16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Prostate gland</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
212-14-7337		MR. CHESTER B. WOLFE		BETWEEN ONSET AND DEATH 6 mo. 6 yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1968</u> , to <u>Aug. 18, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug. 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Lloyd A. Hoffman</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>8/19/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22e. ADDRESS <u>214 N. Potomac St. Hagerstown, Md</u>							
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		8/20/68		LONGMEADOW CHURCH CEM.		HAGERSTOWN WASH. MD.			
24. FUNERAL DIRECTOR <u>W. J. Norment Hagerstown, Md</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		DATE <u>AUG 22 1968</u>		<u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last <b>Henry Christian LEggard Wolffsen</b>						2a. DATE OF DEATH Month Day Year <b>August 17, 1968</b>			2b. HOUR <b>7:30 AM</b>		
3 SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>JAN. 1, 1897</b>			6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Denmark</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2 W. Wilson Blvd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Supervisor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>organ mfg.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. CITY OR TOWN <b>Washington</b>		13c. CITY OR TOWN <b>Maugansville</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <b>Caspa r Wolffsen</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Anine Catherine</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO <b>214-09-8610</b>		17. INFORMANT Address <b>Mrs. Lillian Spielman, Maugansville, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4124</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>40</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 28, 1967</b> to <b>Aug</b> , 1968, that (I) (we) last saw the deceased alive on <b>July 24</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Chas. C. Spencer, MD</b>						DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/17/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Charles C. Spencer</b>						22e. ADDRESS <b>145 S. Prospect St., Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>8-19-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home, Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR <b>Aug 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



FOR STATE  
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12215

1. DECEASED-NAME (Type or Print) <b>Joseph Randall Yeagle</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 8-18-68			2b. HOUR 1:05 P.M.			
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>6-26-1946</b>	6. AGE (in years last birthday) <b>22</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	IF UNDER 24 HRS. MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>August 18, 1968</b>	2d. HOUR 2:25 P.M.
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			9d. HOUR 2:25 P.M.
10. CITY OR TOWN OF DEATH <b>Ft. Ritchie</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Md.#81 &amp; Royer Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U.S. Government</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Marine Corps</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna.</b> COUNTY <b>Bucks</b>			13b. CITY OR TOWN <b>Bristol</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>711 Old Orchard Lane</b>		
14. FATHER'S NAME First <b>Randall F.</b> Middle <b>Yeagle</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Edna M.</b> Middle <b>Hellings</b> Last <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mr. Randall F. Yeagle Bristol, Penna.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> <b>816.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Fourth degree burns on entire body</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8234</b>									
19a. DATE OF OPERATION <b>8-18-68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>auto crashed into private residence</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>1:05</b> P.M. <b>8-18-68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>auto crashed into private residence</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>MD #81 &amp; Royer Rd.</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Ft. Ritchie, Washington, Co., Md.</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL OR CREMATION <b>Removal</b>		23b. DATE <b>8-19-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bristol, Pennsylvania</b>		23d. LOCATION (City or Town) (County) (State) <b>Bristol, Pennsylvania</b>		23e. DATE SIGNED <b>8-18-68</b> <b>215 W. Wash. St.</b> <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. E. Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PMA-100. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

WASHINGTON, D.C. 20535  
JAN 10 1964  
MEMORANDUM  
TO: THE ATTORNEY GENERAL  
FROM: THE DEPARTMENT OF JUSTICE  
SUBJECT: [Illegible]

[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a memorandum or report.]

WASHINGTON, D.C. 20535  
JAN 10 1964  
MEMORANDUM  
TO: THE ATTORNEY GENERAL  
FROM: THE DEPARTMENT OF JUSTICE  
SUBJECT: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12206 CERTIFICATE OF DEATH									
12216									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
MARCELINE			MAE ZOMERO			AUGUST Month 9 Day 68 Year			2:30 a.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
FEMALE		WHITE		MAY 2, 1924			44 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND		U.S.A.					WASHINGTON Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN			WASHINGTON COUNTY HOSP.			HOMEMAKER			OWN HOME
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
MARYLAND			WASHINGTON			HAGERSTOWN		YES	140 W ANTIETAM ST.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
CECIL			HAINES			MYRTLE MULLENDORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO			219-20-1087			140 W Address ANTIETAM ST. HAGERSTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PRIMARY CARCINOMA OF BREAST</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>1 yr.</u> <u>2 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>170X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>65</u> , to <u>8/9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Donald E. Martin</u> DEGREE <u>M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8/9/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>DONALD E. MARTIN, M.D.</u>					22e. ADDRESS <u>363 S CLEVELAND, HAGERSTOWN, MARYLAND</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL		<u>8/12/68</u>		ROSE HILL CEMETERY			HAGERSTOWN, WASHINGTON		
24. FUNERAL DIRECTOR <u>Charles S. Ronger</u>					ADDRESS <u>HAGERSTOWN, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>Aug 12 1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

